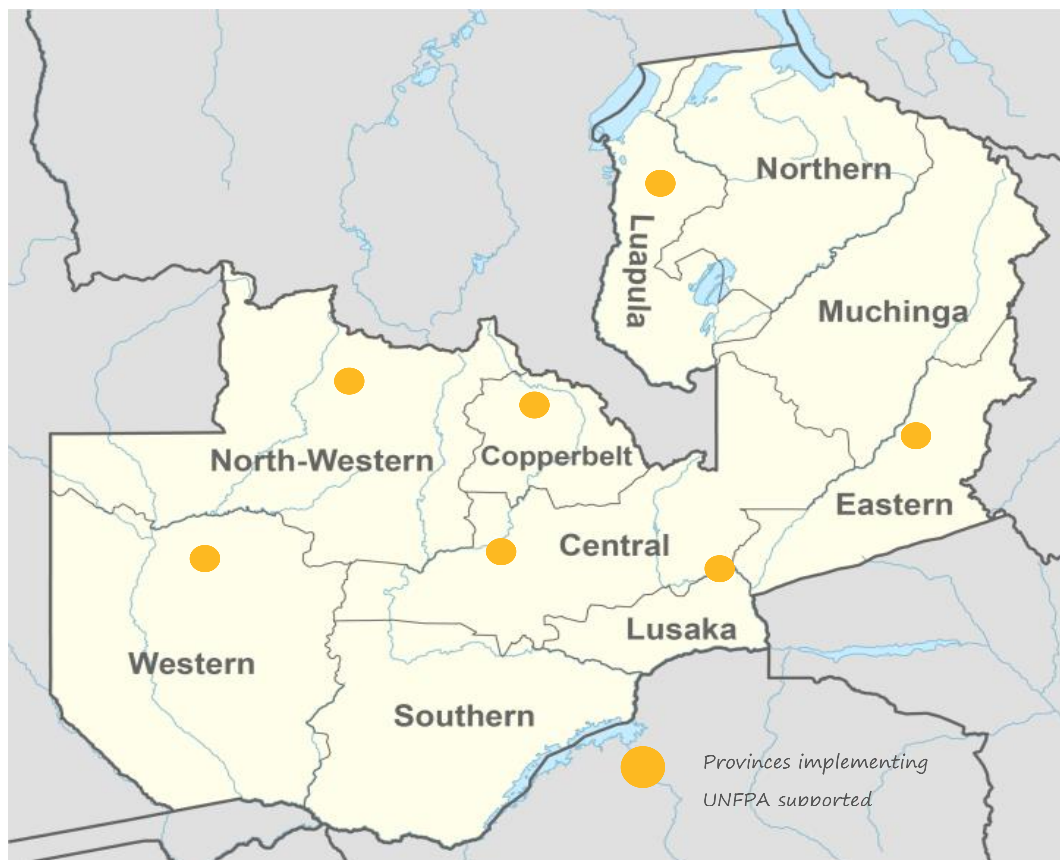
GRZ/UNFPA 8th Country Programme Evaluation: Zambia

Period covered: 2016 - mid 2019

Final Evaluation Report

November 2019

Map of Zambia with UNFPA Supported Provinces



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Acknowledgments

The evaluation team would like to extend our warm appreciation to UNFPA for the opportunity to undertake this end evaluation of the GRZ/UNFPA 8th Country Programme 2016-2020 (extended to 2021). We would like also to extend our appreciation to the Department of Population and Development in the Ministry of National Development Planning for the overall coordination of the evaluation. Their leadership role throughout the process contributed to a quality-assured evaluation.

In particular we valued the capable, diligent support and guidance of the Evaluation Manager, Rita Magawa, and Lisa Gullbransson who provided support in her absence, to Margaret Thwala Tembe, to the Country Representative Gift Malunga for her warm encouragement and guidance, to Sibeso Mululuma, Isabella Aphiri and the Deputy Representative Leonard Kamugisha and, importantly, the support of all programme managers and staff who generously gave their time to talk with us, facilitate the process, and provide critical documents, links and information. Our thanks also to everyone who competently facilitated all the logistics for the evaluation, including the administrative staff and drivers both in the country office and in the sub-offices, and to Nachilima Kaunda, Elizabeth Kalunga and Marshal Mizanda for their time, patience and support in ensuring that we managed to achieve our intended stakeholder visits in Lusaka and in the provinces and districts supported by UNFPA.

In addition, we would like to express our gratitude to all stakeholders in government, the international development community, civil society implementing partners, training schools, primary and secondary beneficiaries and other stakeholders for meeting with us and sharing their knowledge and insights, and also for the additional documentation that some could provide. In particular, our warm thanks to the provincial nursing officers, Hellen Mahamba in North-Western Province, Mercy Kanswata in Luapula Province, Sidney Monze in Central Province, and Obbie Shibwangu in Western Province, and also district staff, who escorted and introduced us in the provinces and districts respectively, and to all the health facility staff for their time and for organising group discussions with community volunteers and beneficiaries.

We also extend our appreciation to the Evaluation Reference Group for their valuable comments, enabling us to strengthen both the research design and the quality of the evaluation report, and to all stakeholders contributing to quality assurance of the evaluation report.

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Abbreviations and acronyms

7CP	GRZ/UNFPA 7th Country Programme
8CP	GRZ/UNFPA 8th Country Programme
7NDP	7th National Development Plan
AIDS	Acquired Immune Deficiency Syndrome
ASRHR	Adolescent Sexual and Reproductive Health and Rights
AWP	Annual Work Plan
AY	Adolescents and Youth
CAPI	Computer Assisted Personal Interview
CBDs	Community Based Distributors
CBF	Common Budgetary Framework
CBV	Community Based Volunteer
CCA	Common Country Assessment
CO	Country Office
COARs	Country Office Annual Reports
CP	Country Programme
CPD	Country Programme Document
CPE	Country Programme Evaluation
CPR	Contraceptive Prevalence Rate
CSE	Comprehensive Sexuality Education
CSO	Central Statistical Office
CSO	Civil Society Organisation
DD	Demographic Dividend
DHO	District Health Office
DHS	Demographic and Health Survey
DPP	Population and Development Directorate (in MNPD)
ERG	Evaluation Reference Group
ESARO	East and Southern Africa Regional Office (UNFPA)
EU	European Union
FGI	Focus Group Interview
FP	Family Planning
GBV	Gender Based Violence
GDP	Gross Domestic Product
GEEW	Gender equality and empowerment of women
GIS	Geographical Information System
GPS	Global Programming System
GRID3	Geo-Referenced Infrastructure and Demographic Data for Development
GRZ	Government of the Republic of Zambia
HCP	Health Care Provider
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
ILO	International Labour Organisation
IMR	Infant Mortality Rate
IOM	International Organization for Migration
IP	Implementing Partner
KI	Key Informant
LARCs	Long-acting Reversible Contraceptives
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
LMIC	Lower Middle Income Country
LMIS	Logistical Management Information System
MDGi	Millennium Development Goals Initiative
MDSR	Maternal Deaths Surveillance Register
MMR	Maternal Mortality Rate
MNDP	Ministry of National Development Planning
MNH	Maternal and Neonatal Health
MoCTA	Ministry of Chiefs and Traditional Affairs
MoG	Ministry of Gender
MoGE	Ministry of General Education
MoH	Ministry of Health

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MoYSCD Ministry of Youth, Sports and Child Development
MTP Medium Term Plan
MTR Mid-Term Review
NAC National HIV/AIDS/STI/TB Council
NASF National HIV and AIDS Strategic Framework
NGO Non-Governmental Organisation
NSDI National Spatial Data Infrastructure
NSDS National Strategy for the Development of Statistics
OECD Organization for Economic and Cultural Development
OSC One Stop Centre
PD Population Dynamics
PDD Population and Development Directorate (of the MNDP)
PHO Provincial Health Office
PMTCT Prevention of Mother to Child HIV Transmission
PPAZ Planned Parenthood Association of Zambia
PPU Provincial Planning Unit
PWD People who inject drugs
RBM Results Based Management
RF Results Framework
RHC Rural Health Centre/Clinic
RHR Reproductive Health and Rights
RMNCAH-N Reproductive, Maternal, Neonatal, Child and Adolescent Health and Nutrition
RRF Results and Resources Framework
SAE Small Area Estimation
SAfAIDS Southern Africa HIV and AIDS Information Dissemination Service
SDGs Sustainable Development Goals
SGBV Sexual and Gender Based Violence
SIS Strategic Information System
SMAGs Safe Motherhood Action Groups
SP Strategic Plan (UNFPA)
SRHR Sexual and Reproductive Health and Rights
TFR Total Fertility Rate
TWG Technical Working Group
UBRAF Unified Budget, Results and Accountability Framework
UNAIDS United Nations Joint Program on AIDS
UNCT United Nations Country Team
UNDAF United Nations Development Assistance Framework
UNDP United Nations Development Programme
UNEG United Nations Evaluation Group
UNESCO United Nations Education, Scientific and Cultural Organisation
UNFPA United Nations Population Fund
UNICEF United Nations Children Fund
UNV United Nations Volunteer
WFP World Food Programme
WHO World Health Organization
YWCA Young Women's Christian Association
ZAPD Zambian Agency for Persons with Disabilities
ZMW Zambian kwacha

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Structure of the Country Programme Evaluation (CPE) Report

After the starter pages that introduce the consultants and include the map of Zambia, the table of contents, list of tables and figures, abbreviations and acronyms, the key facts table and executive summary, the evaluation report consists of six chapters as follows. Chapter 1 is an introduction including the purpose and objectives of the CPE, the scope of the evaluation, and the methodology and process. Chapter 2 provides an overview of the country context, including development challenges and national strategies and the role of external assistance. This is followed in Chapter 3 by the UN and UNFPA responses and programme strategies, addressing the UNFPA strategic response and the response through the country programme, a brief description of the previous cycle and the current country programme, and the financial structure of the programme. Chapter 4 is the most extensive chapter covering the findings on all evaluation questions at strategic levels and by thematic area addressing relevance, effectiveness, efficiency, sustainability and coordination. This is followed by conclusions in Chapter 5 and the linked recommendations and lessons learned in Chapter 6. In addition to the chapters of the report, the CPE provides several annexes, notably the terms of reference, list of institutions and persons met, documents consulted, Atlas Projects, evaluation matrix, main tools and progress against SDGs.

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Table 1: Key Facts Table[1]

Land	
Geographical location	Southern Africa
Land area	752,612 sq. km.[2]
People	
Population (2019)	17.4 million[3]
Male/Female Population	49%/51% (ibid)
Urban /Rural Population	43.1% / 56.9% (ibid)
Population growth rate	2.8%[4]
Government	
Type	Republic, Constitutional Democracy
Key political events	Independence day24 October, 1964 Adoption of Amended Constitution 2016
Economy	
GNI per capita 2018 (Atlas method) PPP USD	1,430[5]
GDP growth rate	3.7%[6]
Main Economic Activity	Mining and Agriculture
Social Indicators	
Human development index / rank	0.586 / 139[7]
Youth Unemployment Rate (Total)	17.4%[8]
Youth Unemployment Rate, Male/Female	16.2% / 19.1%
Life expectancy at birth, Male / Female (years)	52.2 / 56.9[9]
Under 5 mortality (per 1000 live births)	61[10]
Maternal mortality (deaths of women per 100,000 live births)	278 (ibid)
Total fertility rate (children per woman)	4.7 (ibid)
Births attended by skilled health personnel (%)	80% (ibid)
Health Expenditure (as % of GDP)	4.5%[11]
Contraceptive prevalence rate (modern methods)	48%[12]
Unmet need for family planning (% of currently married women, 15-49 years)	19.7% (ibid)
Literacy (% aged 15-49 years)	83% men, 67.5% women[13]
Proportion of women aged 15-19 years who have already begun childbearing	29.2% (ibid)
People living with HIV, 15-59 years	960,000[14]
HIV prevalence rate, 15-49 years (%)	11.4% (ibid)
HIV prevalence, 15-24 years: Male/Female (%)	8.3% / 14.3% (ibid)
Male Medical Circumcision 15-59 years (%)	21.2% (ibid)
Gender Based Violence Prevalence rate	47%[15]

***See Annex 7 for Progress Against Sustainable Development Goals in Zambia.**

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[1] Where available, data are taken from the preliminary 2018 ZDHS report, otherwise from the 2013/14 ZDHS or other sources as indicated; ibid refers to the source immediately before the data indicated
[2] Central Statistical Office, 2010 Census of Population and Housing Analytical Report, 2012
[3] Central Statistical Office, Population and Demographic Projections 2011-2035, 2013
[4] Central Statistical Office, 2010 Census of Population and Housing Analytical Report, 2012
[5] World Bank - https://data.worldbank.org/country/zambia
[6] Ministry of Finance, Annual Economic Report 2018
[7] United Nations Development Programme, Zambia Human Development Report 2016,
[8] Central Statistical Office, 2017 Labour Force Survey Report, 2018
[9] Central Statistical Office, Zambia in Figures 2018
[10] Central Statistical Office, Zambia Demographic and Health Survey Preliminary Report, 2018
[11] World Bank - https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=ZM
[12] Central Statistical Office, Zambia Demographic and Health Survey Preliminary Report, 2018
[13] Central Statistical Office, Zambia Demographic and Health Survey Report 2013/14
[14] Ministry of Health, Zambia Population-based HIV Impact Assessment 2016
[15] Central Statistical Office, Zambia Demographic and Health Survey Report 2013/14

Executive Summary

1. Purpose of the GRZ-UNFPA Country Programme Evaluation, 2016-2020

The UNFPA Zambia country office (CO) commissioned the end of country programme evaluation (CPE) to:

- Enhance the accountability of UNFPA for the relevance and performance of the country programme;
- Broaden the evidence base for the design of the next programme cycle; and
- Generate a set of clear forward-looking and actionable recommendations logically linked to the findings and conclusions, identifying key lessons learned from past and current cooperation.

The CPE will also influence the current cycle that is being extended to 2021 to align with the Zambia national development planning and UN partnership programme cycles. The intended audience includes the Zambia UNFPA CO, partners and stakeholders, the regional office and headquarters, and the UNFPA Executive Board. The report and the evaluation quality assessment are also made available on the UNFPA website to reach a wider interested audience.

2. Evaluation Objectives and Country Programme (CP) Outline

The objectives of the independent CPE[16] were to assess:

- The relevance, effectiveness, efficiency and sustainability of UNFPA support and progress towards the expected outputs and outcomes of the CP results framework;
- The positioning of the CO within the developing community and national partners, its ability to respond to national needs while adding value to the country development results;
- The role of the CO within the United Nations Country Team (UNCT) coordination mechanisms to enhance the United Nations collective contribution to national development results; and
- The extent to which the implementation framework enabled or hindered achievements of the results chain (i.e. what worked well and what did not work well).

The CP has three thematic areas, sexual and reproductive health, adolescents and youth, and population dynamics, with particular attention to the cross-cutting issues of gender and gender based violence (GBV), human rights and disability. The emphasis at output level is on institutional capacity development to address these thematic areas at national, provincial and district levels, and increased availability of disaggregated evidence on population, SRH, HIV and gender equality. To achieve the outputs, the CP has employed all five modes of engagement: advocacy and policy dialogue; capacity development; knowledge management; partnership and coordination, and service delivery.

3. Methodology

The CPE had five phases. First was **preparation**, when the CO, with Ministry of National Development Planning support, engaged an evaluation reference group (ERG), developed terms of reference and recruited the three consultants, one international and two national. After this, the consultants undertook evaluation **design** and production of a design report; the **field** phase of data capture and analysis; and **reporting** and presentation to the CO, then to the ERG and stakeholders interviewed followed by further revisions; and the **facilitation of use and dissemination phase** in which the CO implements the full communication plan to share the report, and final evaluation quality assessment prior to the management response and publication of the report.

The revised Handbook 2019[17] guided the entire evaluation process and drafting of the design and evaluation reports according to the prescribed structures and content. First, the evaluation involved developing the design report describing the evaluation and presenting the stakeholder selection, evaluation matrix and tools for approval by the CO and ERG, as well as a brief country situation and response analysis and outlines of the previous and present country programmes. It also involved reviewing the CP theory of change. Second, the evaluation team undertook data capture, analysis and triangulation utilizing extensive document review, field visits, semi-structured key informant interviews in the office and with stakeholders drawn from the full range of partners, and focus group discussions with primary and secondary beneficiaries. The evaluation was thus highly participatory and full confidentiality was assured. The consultants provided

[16]Terms of Reference for UNFPA 8CPE, 11 July 2019
[17] Evaluation Handbook: How to Design and Conduct a Country Programme Evaluation at UNFPA, 2019

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draft and final evaluation reports as indicated above, incorporating feedback initially from the CO and then from the ERG and stakeholders, and in response to evaluation quality assessment. The purpose and objectives of the CPE were fully met with strong CO support, despite reduction in the evaluation team during the reporting phase.

4. Main Conclusions

The **strategic conclusions** of the evaluation are that the 8CP has been fully aligned to international and national priorities and commitments and was adjusted appropriately to the new global UNFPA Strategic Plan in relation to all three transformational goals. Programming has been effective in achieving targets in the thematic areas, utilising all five modes of engagement contributing to policy and strategy development, capacity building at all levels, knowledge management, partnership and coordination and strengthened service provision. The theory of change behind the results chain could be stronger regarding interventions to achieve outputs and linked indicators. Strong resource mobilisation was achieved, although funding for adolescents and youth was low, and budget utilisation rates were high. The CO has clearly added value to addressing national development needs in sexual and reproductive health, for adolescents and youth, and in population data, and in responding effectively to a humanitarian situation that arose. As well as national level engagement, UNFPA has continued the strategy of prioritising provinces and districts with poorer SRH indicators, and has mainstreamed gender and a human rights focus, for instance addressing gender based violence (GBV), fistula survivors and child marriage. Some sustainability of results is apparent, for instance regarding maternal health, in integrated SRH services, and in influencing the National Development Policy, and UNFPA has been an active and effective partner in the UN Country Team and in extensive delivering as one (DaO) through joint programming in line with the UN Joint Sustainable Development Partnership Framework. The overall office structure and complement, including three provincial sub-offices, have been effective (although there has been no substantive population and development specialist during the 8CP). Efficiencies appear generally satisfactory, with improvements in the latter during the life of the CP, but there appears to be a heavy work load on operations and administration with complex financial systems and changing on-line modalities. These had teething problems but should become more effective over time leading to greater efficiencies. Recently approved funding for an increased staffing complement seems well justified to strengthen office operations and scale up programming. **Main challenges** include: the extent of programming needs are high with severe economic, gender and geographical inequalities and widespread poverty, and limited fiscal space for health. This has potentially negative implications for reducing service delivery despite the country's LMIC status and efforts by UNFPA and others to increase domestic funding for health and SRH. Although robust M&E plan and systems are in place, quality assurance at facility and implementing partner levels are not sufficient in practice. Delay in disbursement of funds in the first quarter delays programming across the thematic areas.

Regarding **sexual and reproductive health** (SRH), integration of SRHR, HIV and gender based violence (GBV) has been achieved in the focal provinces and districts and has been described as catalytic in strengthening government focus on primary health care and endorsing integration. UNFPA has made extensive contributions to e.g. the H6 partnership and RMNCAH&N policy and programming, and through health provider capacity development, particularly in midwifery. Contributing to reduced maternal mortality, considerable strengthening of emergency maternal, obstetric and neonatal care services (EmONC) is evident in the focal provinces and districts, and successful training and retention of safe motherhood action group members who have raised community awareness, demand and uptake. They have also helped identify women with fistula for referral for treatment, and to help prevent fistula by early recognition of risk. Fistula camps have been implemented but are not sustainable, and surgeons trained. Community based distributors have had capacity built to promote demand and to widen the method mix available in the community, reducing pressure on health facilities and increasing access to long-acting reversible contraceptives as well as male and female condoms. Procurement of reproductive health commodities has remained high (around 50 per cent of national needs), and supply chain management has been strengthened. **Main challenges include** (in addition to those noted above): regarding GBV, although the SRHR response has improved, seeking judicial redress remains very limited and beyond UNFPA's mandate; the inclusion of people with disabilities has begun but is not yet well developed, and the focus on key populations of sex workers and men who have sex with men is limited although UNFPA contributed to the focus on key populations in the Zambia strategy and road map on HIV and AIDS. Increasing FP rates continues to be a challenge.

With respect to **adolescents and youth**, two core output areas were addressed with extensive interventions on raising in and out-of-school comprehensive sexuality education (CSE) and addressing child marriage. UNFPA has contributed to strengthened policies, strategies and programmes for young people, addressing their integrated SRHR, HIV and GBV needs, knowledge, demands, and access to adolescent friendly service provision. In-school curricula have been revised to strengthen the aspects relating to sexuality and gender, and CSE has been made an examinable subject, integrated into carrier subjects. Adolescent girls and young women have been the priority focus but with male involvement also. Extensive peer educator training and deployment has been achieved in districts supported by UNFPA to increase demand

and contribute to knowledge, motivation to access services, and condom supply. Programming to reduce child marriage has included influencing policy and addressing traditional attitudes and raising community awareness of the risks inherent in child marriage (mainly girls). UNFPA has engaged in strategic partnerships to develop safe spaces for adolescent girls and promote social and economic asset building with mentorship programmes. **Main challenges** include: low levels of funding for the adolescent and youth thematic area, despite continuing high needs and poor indicators (especially for teen pregnancy, HIV incidence in young women, GBV and child marriage); the need to ensure sufficient integration of SRH, gender and adolescent and youth teams within the office and/or adequate staffing levels; and high attrition among peer educators plus the low quality of adolescent safe spaces in health facilities.

In **population dynamics**, the UNFPA CO contributed extensively financially and technically to: data generation in the 2018 Zambia Demographic and Health Survey and 2020 Census, undertaking preparatory activities and use of cutting-edge technology; integration of population dynamics in the Seventh National Development Plan (7NDP); strengthening national policies through the revised National Population Policy; domestication of SDGs in the 7NDP through a National Coordination and Implementation Framework; and capacity development in utilisation of evidence-based data on population dynamics in development plans and programmes at sub-national level. The **main challenges** were limited financial resources, e.g. to undertake the main pilot census and complete the country-wide mapping exercise; and although sustainability and ownership of programmes is guaranteed, national level coordination needs improvement.

5. Main recommendations

At **strategic level** UNFPA should consider designating UNFPA Zambia a ‘big’ country office with increased core funding. The CO should continue at present utilising all five modes of engagement to address the three component areas while gradually considering reduced service delivery. Quality assurance of programmes and projects should be strengthened with adequate finance to ensure regular M&E and further capacity building among staff and implementing partners as needed. UNFPA should sustain its proactive positioning in the UNCT and with DaO, expanding strategic joint programming based on experience in the 8CP. Consideration should be given to unfreezing the population specialist post. Lessons should be learned from programmes that have shown significant results, in particular through strategic joint programmes, and intensification of effort in existing focal areas and/or widening geographical scope should be considered to achieve greater results. No major shift in general priorities and programming appears needed beyond those specifically noted. Further refinement of the theory of change behind the results chain is indicated.

Regarding **sexual and reproductive health**, the next CP should build on the experiences and achievements of the 8CP, particularly learning from joint programming in RMNCAH&N, the Millennium Development Initiative and other programmes with proven results. Training and retention of community volunteers will remain important. Greater attention should be paid to programming for key populations and to people with disabilities, and the CO might consider adopting rights based language. With regards fistula, the opportunity to revise engagement should be strategically addressed with a road map being developed and a new partner in the field, Fistula Foundation.

Adolescents and youth should remain a thematic area given the extent of need in the youthful population structure, but integration of programming and management with wider SRH could be strengthened. Programming for young people, particularly marginalised adolescent girls and young women, should be strengthened and scaled up with increased budgets commensurate with the high level of unmet need. This should continue the focus on CSE in and out-of-school, on strengthened adolescent corners in health facilities and expanded provider training on ASRH, and also on child marriage, Programming should expand to include other particularly marginalised young people such as those with disabilities or in key populations.

Regarding **population dynamics**, UNFPA should continue to contribute to large scale national and sub-national data generation for evidence-based development planning and programming at national and sub-national levels, promoting close collaboration between all stakeholders and ensuring that the next National Development Plan remains aligned to the SDGs. UNFPA should also continue to strengthen comprehensive capacity for data dissemination and utilisation to ensure continued integration of population dynamics in sectoral policies and plans in line with the National Population Policy, supporting sub-national analysis and harmonisation of statistical systems. UNFPA needs to monitor whether taking on a UNV for population dynamics is sufficient or whether to unfreeze the specialist post.

Lessons learned

Strategic level

By supporting strategic partnerships within the UN system and with government and other stakeholders, and providing financial and technical support to the Ministry of National Development Planning, the UNFPA CO successfully

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contributed to the domestication of SDGs into the 7NDP, resulting in the National SDG Coordination and Implementation Framework against which to monitor progress and sustain close alignment in development planning.

Transition to increased domestic funding and reduction of service delivery as a mode of engagement will be challenging with the level of GRZ financial resources and capacity, despite the LMIC designation, given the extent of prevailing inequalities in Zambia and stagnation of economic growth in recent years.

The delivering as one focus is progressing well and achieving greater financial and technical synergies at national and programming levels, particularly when joint initiation of programme design and planning are undertaken from the start.

Introducing more streamlined monitoring and reporting tools to strengthen efficiencies has been appropriate, but the extent to which both UNFPA staff and implementing partners need capacity development to use them effectively should not be underestimated.

SRH

The integrated SRH, HIV and GBV focus is relevant, efficient and appreciated, highly unlikely to have emerged without UNFPA leadership, and scaling up requires sufficient quality assurance regarding fidelity to key components.

Mainstreaming of gender, human rights and disability are apparent in the 8CP and could benefit from utilising a clear rights based framework to enhance the focus, with stronger attention to the rights of particularly vulnerable populations.

Adolescents and youth

Creating a thematic area for the integrated SRHR response for young people is well justified given the young population structure and socio-economic vulnerability of young people, especially girls within a patriarchal society, and requires sufficient financial allocations and synergistic integration with the wider SRHR and gender focus within the CO.

Population dynamics

Given that no other agency contributes to population dynamics, the contribution of UNFPA to strengthen capacity for generation, dissemination and utilisation of population data at all levels and to provide high level technical and financial support remains a high priority.

The sub-national analysis and production of sub-national profiles, including sex and age disaggregated data at province, district, constituency and ward levels for integration of population dynamics, has been instrumental in increasing the dissemination and utilisation of evidence-based data in development plans and programming at all levels, as well as the identification of vulnerable populations and most needy geographical areas.

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Chapter One: Introduction

1.1 Purpose and Objectives of the Country Programme Evaluation

The 8th Country Programme Evaluation (8CPE) was commissioned by the UNFPA Zambia Country Office (CO) with the purpose of: 1) Enhancing the accountability of UNFPA for the relevance and performance of the country programme; 2) Broadening the evidence base for the design of the next programming cycle; and 3) Generating a set of clear forward-looking and actionable recommendations logically linked to the findings and conclusions. In addition to contributing to planning for the next programme cycle, the findings, conclusions and recommendations of the CPE should influence the current cycle that is being extended to 2021 to align with the Zambia-United Nations Sustainable Development Partnership Framework (2016-2021) and the 7th National Development Plan (2017-2021).

Specifically, the objectives of the CPE[18] were to:

i. Provide an independent assessment of the relevance, effectiveness, efficiency and sustainability of UNFPA support and progress towards the expected outputs and outcomes of the CP results framework;

ii. Provide an assessment of the country office's positioning within the developing community and national partners, in view of its ability to respond to national needs while adding value to the country development results;

iii. Provide an assessment of the role played by the UNFPA country office 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;

iv. Assess the extent to which the implementation framework enabled or hindered achievements of the results chain (i.e. what worked well and what did not work well);

v. Draw key lessons from past and current cooperation and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the extended 8CP and the next programming cycle.

1.2 Scope of the Evaluation

The evaluation addressed the three programme component areas of sexual and reproductive health, adolescents and youth, and population dynamics, and the cross-cutting areas of a human-rights based approach and mainstreaming of gender and disability. It also focused on strategic coordination and partnerships, overall office typology, management and financing, and monitoring and evaluation.

The evaluation assessed the interventions planned and/or implemented within the current CP from 2016 to the end of the second quarter of 2019. The time frame of the evaluation was from 11 July to 12 October 2019. Geographically, field work took place in the five of the provinces with UNFPA-supported interventions, Central, Luapula, Lusaka, North-Western and Western provinces, as well as addressing national programming.

1.3 Methodology and Process

1.3.1 Methodology

1.3.1.1 Evaluation criteria

The standard evaluation criteria drawn from the United Nations Evaluation Group and the Organization for Economic Cooperation and Development guided the development of the CPE as articulated in the UNFPA Handbook19 and the ToR for the evaluation (Annex 1). The criteria include assessing relevance (and responsiveness), effectiveness, efficiency, sustainability and coordination. Also included is addressing the cross-cutting issues of gender and disability mainstreaming and a human rights approach, and synergies between the programme areas. The issue of added value by the UNFPA CP is reflected where relevant (e.g. regarding effectiveness and sustainability of results, and also coordination). The strategic positioning of UNFPA also emerges within the focus on relevance and on coordination. The

[18] Terms of Reference for UNFPA 8CPE, 11 July 2019
[19] UNFPA Evaluation Handbook 2019: How to Design and Conduct a Country Programme Evaluation

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analysis of the CP is set within the context of the Sustainable Development Goals, the global UNFPA mandate, the Zambia-UN Strategic Partnership Framework, and the national country context.

The evaluation applied a theory-based approach i.e. the evaluation methodology was based on the careful analysis of the intended outcomes and outputs, activities implemented, as well as contextual factors and their effect on desired outcomes. A preliminary country programme theory of change (ToC) was developed by the CO as part of the design phase to elucidate the logic of the programme results chain in each component area. The ToC, with amendments by the evaluation team, reflects the conceptual and programmatic approach taken by UNFPA Zambia over the period under evaluation including modes of engagement used in programme delivery, guiding principles, the intervention logic and causal links, expected changes as well as risk factors and critical assumptions. The ToC played a central role in shaping the evaluation matrix that guides the data collection and analysis throughout, in the reporting of findings, and in the development of conclusions and of relevant and practical recommendations.

The ToC was tested during the field and data collection phase using the evaluation matrix and is reconstructed as below. Some minor adjustments were made that reflect gaps found in the original ToC, for instance the addition of the transformational goals, and the addition and minor adjustments to full modes of engagement in each thematic area. The outputs in the ToC for sexual and reproductive health and adolescents and youth all relate to national, provincial and district level capacity development. The district level includes the facility and community levels that are addressed extensively throughout the CP, and it would be useful to indicate this explicitly. The assumptions and risks in the ToC fit well with the assumptions in the evaluation matrix, particularly with respect to fiscal space and increasing health allocations to provide sufficient trained staff at all levels and to maintain services.

There were some challenges in the alignment of activities and interventions against indicators (noted in EQ2 under the thematic areas) and closer attention should be paid to these in developing the results chain logic for the next CP. During the field work it also became clear that direct engagement with parliamentarians and policy makers might better describe advocacy and policy dialogue actions than ‘accountability frameworks. This is reflected in the revised ToC.

Minor amendments were made to the evaluation matrix (annexed) in relation to assumptions and to EQ5 on coordination. Originally the EQ on coordination only addressed the United Nations Coordination Team, UNCT, and whether the UNFPA priorities are well reflected in the UN Joint Strategic Partnership Framework. It became clear during field work that the overall contribution to delivering as one at all levels from the UNCT down, and the overarching commitments in the Partnership Framework to specific joint programming, were more logically covered under this question if they did not fit neatly into interventions under specific thematic areas. Thus the findings on partnership and coordination include the high level commitments and engagement of UNFPA through to the people-centred programming on the ground. Also, the question was widened to include the alignment of indicators and targets as well as pillars of the Framework.

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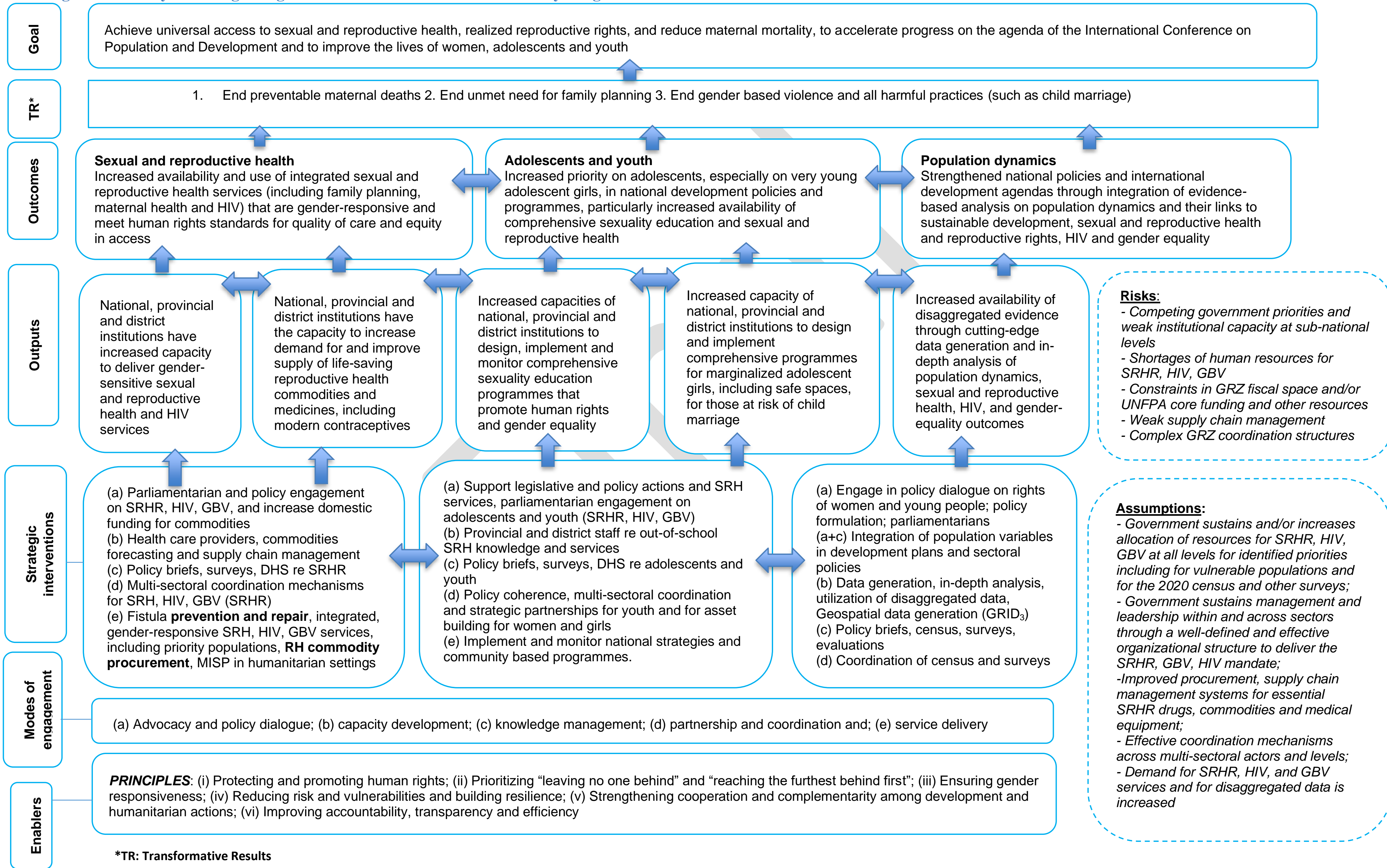
Figure 1: Theory of Change Diagram for the GRZ/UNFPA 8th Country Programme



1.3.1.2 Evaluation questions

The evaluation team developed the overarching questions below based on the guidance noted above, drawing mainly on the Handbook and in consultation with the CO. The changes noted above are incorporated here.

EQ1: Relevance

a. To what extent is the country programme aligned with the goals of the ICPD Programme of Action, SDGs and the strategies of UNFPA and adapted to: national needs, policies and development plans; priorities of the programme stakeholders and priority groups, particularly the vulnerable and marginalized (such as young people with disabilities)?

b. To what extent has the country office been able to respond to changes in national and provincial needs and priorities or to shifts caused by major political or humanitarian change? What was the quality of the response, particularly in relation to vulnerable and marginalized populations?

EQ2: Effectiveness

a. To what extent did the interventions supported by UNFPA in all programmatic areas contribute to the achievement of planned results (outputs and outcomes), and how far were the planned geographical areas and target populations successfully reached in terms of coverage and quality of programmes?

b. To what extent has the programme mainstreamed gender and human rights-based approaches, including for people with disabilities?

c. To what extent did UNFPA contribute effectively to data generation and sustained increase in the use of disaggregated and evidence-based demographic and socio-economic data in policies, planning and programming?

EQ3: Efficiency

a. To what extent has UNFPA made good use of its human, financial, administrative and technical resources and used an appropriate combination of tools and approaches to pursue the achievement of the outputs and outcomes defined in the country programme?

b. To what extent are results effectively and efficiently measured and contributing to accountability in programming?

EQ4: Sustainability

a. How far has UNFPA successfully promoted national ownership regarding its programme areas (policies, increased capacity and budgetary allocation) and integrated SRHR/HIV/GBV into policy, planning and programming?

b. To what extent has UNFPA supported implementing partners and beneficiaries in developing capacities and establishing mechanisms to ensure ownership and durability of effects?

EQ5: Coordination

a. To what extent has the UNFPA Country Office contributed to the functioning and consolidation of UNCT coordination and to delivering as one, including with regards areas of potential overlap while maintaining its mandate?

b. How and to what extent are the UNFPA priorities and mandate reflected in the Zambia-UN Sustainable Development Partnership Framework 2016-2021 pillars, indicators and targets?

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The team probed to elaborate the evaluation questions so that more detailed aspects of the UNFPA CP emerged and, as noted, explored the results chain logic of programme results framework to reconstruct the theory of change as needed.

1.3.1.3 Methods for data collection and data analysis

Data collection involved primary sources (key informant interviews, focus group interviews and site visits) and secondary sources (document review), adopting a participatory process and triangulating data from the various sources. Site visits were also undertaken in the provinces of Central, Luapula, Lusaka, North-Western and Western.

Extensive document review formed the core of the evaluation, triangulated with the primary data from interviews, group discussions and site visits. The full list of documents reviewed is annexed. Interviews involved semi-structured schedules covering the core evaluation questions and probing as needed for each component area. Key informants were drawn from diverse levels, including UNFPA staff and partner UN agencies, donors, government policy makers and programme leads at national, provincial and more local levels, and implementing partners (IPs).

In addition to key informant interviews, the team held focus group interviews with both primary and secondary beneficiaries using semi-structured interview schedules. Primary beneficiaries included women, girls and boys (interviewed as separate groups) reached with UNFPA-supported interventions. Secondary beneficiaries included implementing partners and government staff such as health staff trained with UNFPA support. Section 1.3.4 describes stakeholder selection. Qualitative information from the beneficiaries assisted analysis of programme effectiveness, as well as highlighting gaps or challenges.

Site visits contributed to the evaluators' understanding of the overall context in which activities have taken place, and the facilities and resources available. Visits were also intended to facilitate observation of staff/beneficiary interactions beyond what is captured in FGIs or key informant interviews or in reports, although the extent to which this was possible was limited, as visits were scheduled for when staff were available. Site visits were documented through standardised check lists to promote comparability of information, and the core individual and group KI interview and FGI schedules are attached. Specific semi-structured schedules were utilised with different CO staff members.

The United Nations Evaluation Group (UNEG) Code of Conduct, Ethical Guidelines and Norms and Standards informed the whole evaluation process. Throughout, the evaluation team was objective and impartial, ensuring informant confidentiality.

Both quantitative and qualitative data from primary and secondary sources were assessed and referenced, with findings systematically triangulated to ensure that they were robust. The process involved contribution analysis, content analysis and trend analysis. Beneficiary focus group and key informant interviews were assessed through thematic content analysis, and data were quantified, where appropriate, from different primary sources. Contribution analysis identified how far documented inputs and activities were sufficient and relevant to the outputs and outcomes and likely to have contributed meaningfully to them. This involved exploring the theory of change in the results chain logic for each component area of the country programme. The linked trend analysis explored the change in results over time in the quantitative indicators of the CP, leading to conclusions and recommendations concerning the appropriateness and sufficiency of indicators, outputs and targets, and noting factors that may have made effective monitoring a challenge. Where data were ambivalent or conflicted, the evaluation team undertook further interviews, phone contact and/or document review. In addition, the team examined the reasons behind any conflict in data and decided whether to include the data with objective qualifications, or to omit them and explain the data gap. It is stated if robust conclusions and recommendations on a specific area could not be drawn.

The overarching questions are presented in the evaluation matrix (annexed), including for cross-cutting issues of gender, human rights and disability. The core analytical tool of the evaluation that presents the overarching questions, assumptions, indicators, sources of information and methods and tools for data collection. The evaluation matrix provides the link between the main evaluation criteria and the evaluation questions.

1.3.1.4 Selection of the sample of stakeholders

The purposive sampling of stakeholders took into account the comprehensive UNFPA guidelines on stakeholder selection,[20] and sampling was agreed in discussion with the evaluation manager and CO staff. The guidelines require sampling to include: stronger and weaker IPs, and financially large and small programmes and projects; partners from government and civil society organisations (CSOs), donors and, importantly, primary and secondary beneficiaries. Included are UNFPA direct and indirect partners (stakeholders who do not work directly with UNFPA but play a key role in a relevant outcome or thematic area in the national context). The list of stakeholders contacted is annexed, as well as site observations.

Geographical coverage included both Lusaka and the other six provinces where UNFPA supports interventions, and both ongoing and completed activities within the time frame of the CPE. Also covered were regional and inter-agency interventions and the national programmes. The evaluators for SRH and/or adolescents and youth undertook field visits to Central, Luapula, North-Western and Western provinces, including selected districts and sites, as well as covering Lusaka. They did not go to Copperbelt as the remaining provinces were considered an adequate sample for purposes of the evaluation, or to Eastern Province, as the only project in which UNFPA was involved, Phase 1 of the National Ending Child Marriage Programme in Solwezi and Lusaka was recently evaluated, providing relevant information. Phase 2 has begun in two new districts, Katete in Eastern Province and Senanga in Western Province.

With regards the population dynamics component, all main partners were included as there are few, all are based in Lusaka. In relation to coordination and strategic positioning, partners in the United Nations Country Team (UNCT) with whom

[20]UNFPA Evaluation Handbook 2019: How to Design and Conduct a Country Programme Evaluation

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UNFPA has mainly worked, the UN Delivering as One coordinator, and core donors were also selected for interview. The annexes provide further details, and on the selected stakeholders for the SRH and adolescents and youth components.

1.3.2 Limitations Encountered

There were no major limitations encountered during the evaluation process likely to impact negatively on the quality of the CPE. Flexibility was employed by the consultants, IPs and the CO during field work. Compared with the initial field schedule, for instance, too little time had been allocated for the number of IP interviews, site visits and FGIs in the provinces and districts, however, the schedule was adjusted appropriately as field work progressed. Ultimately the range of interviews and visits undertaken was both substantial and sufficient (see Annex 2). However, late in the CPE the national consultant for adolescents and youth was withdrawn, generating heavy pressure on the lead consultant to revise the inputs in a limited time frame and without full access to field notes. Nonetheless, much field work had been undertaken jointly, and the lead consultant undertook additional interviews and cross-checks and further document review, making every effort to triangulate data appropriately.

1.3.3 Evaluation Process

The overall evaluation process involved five phases: (i) preparation; (ii) design; (iii) field; (iv) analysis and reporting; and (v) facilitation of use and dissemination phase. Quality assurance measures were integrated in all the phases.

i) ***Preparatory Phase:*** The ***evaluation manager*** led the preparatory phase that included: preparation and approval of the Terms of Reference (ToR); constitution of the Evaluation Reference Group (ERG) and pre-selection of the evaluation team jointly with the ***Ministry of National Development Planning (MNDP)***; collection of relevant documents; preparation of a stakeholder map from which sampling was made; development of a communication plan for sharing results, with flexibility to incorporate any new opportunities for communication and dissemination.

ii) Design Phase: The ***evaluation team***: reviewed key documents provided by the UNFPA Zambia Country Office and UNFPA Headquarters; in discussion with the evaluation manager, programme staff and the ERG, proposed purposive sampling from the stakeholder map according to the Handbook criteria for selection (see 4.3); assessed limitations to and risks in the evaluation process and identified mitigation measures; reviewed the results matrix and began to consider the intervention logic of the programme, that is the theory of change that underlies the planned activities to address the intended output and outcome results of the programme; finalised the list of evaluation questions and prepared the evaluation matrix; developed a data collection and analysis strategy, as well as a concrete work plan for the field phase in conjunction with the evaluation manager and her delegate; and developed the design report for approval by the ERG and the CO, incorporating recommended amendments. The ***evaluation manager, CO, MNDP and the ERG*** contributed to quality assessment of the design report and its annexes.

iii) Field Phase: The ***evaluation team***: undertook field work with the agreed sample of stakeholders to collect primary data to address the evaluation questions; conducted extensive secondary data (document) review; cleaned, triangulated and analysed data; identified any gaps in data and undertook follow up as needed; and provided a fieldwork debriefing to the CO, including overarching field work experience, findings and challenges faced. The MNDP and the CO coordinated field work.

iv) Reporting Phase: The ***evaluation team*** undertook further analysis and drafting of a zero draft evaluation report for review by the ***CO***. The revised report was submitted to the ***ERG and further validated through a key stakeholders' meeting during which consultations on draft recommendation were undertaken***. A PowerPoint presentation was made and further comments were incorporated. The ***evaluation manager and ESARO Monitoring and Evaluation Advisor*** completed the Evaluation Quality Assessment Grid and the ***evaluation team*** incorporated further feedback to finalise the report.

v) Facilitation of Use and Dissemination Phase: The ***evaluation manager and communications analyst*** implement the communication plan to share the report. ***CO management and units*** prepare the management response with final inputs from the ***lead consultant***. The final evaluation report, the management response, and the final EQA of the report are published on the UNFPA evaluation database and made available to the Executive Board and on the CO website https://zambia.unfpa.org/en/publications.

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Chapter Two: Country Context

2.1 Development challenges and national strategies

2.1.1 General country context

The Republic of Zambia, capital Lusaka, is a land locked country and neighbours Angola, Botswana, the Democratic Republic of the Congo, Malawi, Mozambique, Namibia, Tanzania and Zimbabwe. In 2010, the World Bank declared Zambia a lower middle income country (LMIC), as one of the world's fastest economically reformed countries,[21] although recent years have seen a decline in annual GDP growth from between 6 and 7 per cent between 2010 and 2015, to below 4 per cent in 2018.[22]

The total land mass of Zambia is extensive at 752,610 sq. km, with valleys and high plateaus, and extensive water drainage from the Zambezi basin into the Kafue, Luangwa and Zambezi rivers, and into the Congo basin to the north. Flooding is a recurrent problem in parts of the country, leading to some displacement and challenges in sustaining service access (including for SRHR), and to the need for humanitarian assistance.

The country is divided into 10 provinces and 115 districts. The total population was projected to be 17.4 million in 2019,[23] with young people aged 10-24 years representing 34.4 per cent: population growth is high. Zambia is officially a Christian nation according to the 1996 constitution, but includes a wide variety of religions. [24]

English is the official language, and the population comprises approximately 73 Bantu-speaking ethnic groups, with almost 90 per cent of Zambians belonging to nine main ethno-linguistic groups. This has implications for ensuring that behaviour change communication materials are developed in formats and languages accessible to different groups, particularly given that an estimated one-third of women aged 15-49 are illiterate.[25]

Mining, particularly of copper, and agriculture are the main economic activities that contribute significantly to foreign investment, government revenue and formal employment, both with a long history. The Zambian agriculture sector comprises crops, livestock, and fisheries. There are three broad categories of farmers: small-scale/subsistence, medium, and large-scale, of which the majority is subsistence farmers. Agriculture and fisheries contribute about 19 per cent to GDP and employ three-quarters of the population. Roughly equal numbers of men and women are in employment.

Among key development challenges that Zambia is facing[26] are severe income, gender and geographical inequalities. Despite economic growth, a 2015 poverty report estimates 60 per cent of Zambians live below the poverty line, with extreme poverty levels of 42 per cent in rural areas and over 60 per cent for female-headed households.[27] The same report indicates that Zambia has a 2014 Gini coefficient of 0.65 and Zambia has poor human development indicators.[28] Development challenges include: under-nutrition, with over-reliance on maize contributing to stunting; underemployment and heavy reliance on the informal sector; child labour; and insufficient support to the most needy. In particular, poverty affects children, young people and women, young people and women being focal populations for UNFPA support.

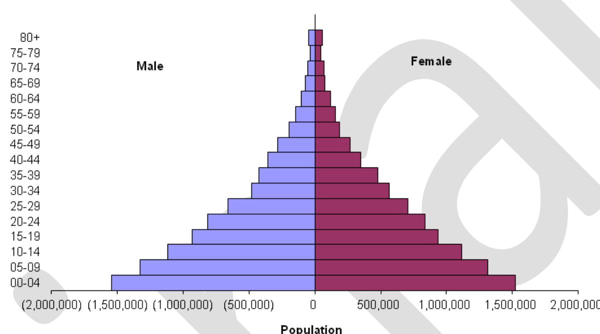
The Seventh National Development Plan (7NDP), the country's blue-print for economic diversification and development for the five years to 2021, envisions a prosperous middle-income economy that offers decent employment opportunities for all Zambians and pays special attention to the vulnerable, marginalized, excluded and/or discriminated against. It is a building block to meet the goals of Vision 2030.[29] Vision 2030 is a long-term plan that expresses the aspirations of the Zambian people to live in a strong and dynamic, middle-income industrial nation that provides opportunities for improving the health and well-being of all.

[21] Ngoma, Jumbe (18 December 2010). 'World Bank President Praises Reforms In Zambia, Underscores Need For Continued Improvements In Policy And Governance'. World Bank.
[22] Republic of Zambia, Ministry of Finance, Annual Economic Report 2018, Lusaka, Zambia.
[23] CSO (2013) Population and Demographic Projections, 2011-2035
[24] Constitution of Zambia, 2016 (Amendment) [No.2 of 2016]
http://www.parliament.gov.zm/sites/default/files/documents/amendment_act/Constitution%20of%20Zambia%20%20%28Amendment%29%2C%202016-Act%20No.%202_0.pdf . Retrieved 31 July, 2019
[25] CSO (2013/4) ZDHS Report
[26] UN Zambia/GoZ (2015) Zambia Country Analysis Summary
[27] Republic of Zambia Central Statistics Office (CSO), 2016, Living Conditions Monitoring Survey Report, Lusaka, Zambia.
[28] UN Zambia/GoZ (2015) Zambia Country Analysis Summary
[29] Ministry of National Development Planning. December 2006. Vision 2030

2.1.2 Challenges and national strategies for population and development

The key challenges regarding population and development in Zambia are high fertility and population growth, insufficiently strong governance, gender inequality, poverty, and inadequate dissemination and, especially, utilisation of available data for evidence-based national and sub-national planning to alleviate these challenges.[30] [31] The Zambia 2010 census enumerated a total population of 13.1 million people comprising 51 per cent female and 49 per cent male.[32] Population projections for the period 2011-2035 based on the census estimate the total population to be 17.4 million in 2019, representing an annual population growth rate of 2.8 per cent.[33] In 2030, the Zambian population is estimated reach 23.6 million.[34] Half of Zambia's population is aged 17 years or below.[35] Zambia's youthful population presents an opportunity for harnessing the demographic dividend with the right policies and investment in health, education, entrepreneurship, leadership, and a human rights approach to development, but also a major challenge to ensure that sufficient educational and employment opportunities can be created.

Figure 2: The Population Age Structure of Zambia, 2019[36]



The total fertility rate has remained high, despite declining from 5.3 children per woman in 2014 to 4.7 in 2018.[37] Fertility in rural areas has persistently remained higher than in urban areas. Socio-cultural beliefs and practices that encourage women to have many children and large families as social insurance in old age largely influence the high fertility rate. Under-five mortality has significantly declined in the period 1992-2018 from 191 deaths per 1,000 live births in 1992 to 61 deaths in 2018.[38] Life expectancy at birth is 56.9 years for females and 52.2 years for males.[39]

Despite the availability of quality disaggregated data generated from national censuses, regular demographic and health and other surveys and other demographic sources by government institutions such as the Central Statistical Office and Department of National Registration, Passport and Citizenship, the utilisation of these data for evidence-based decision making and development planning has remained limited. This has mainly been attributed to inadequate capacity to generate in-depth further analysis of the existing data into user-friendly key socio-demographic and economic indicators that can readily be used to inform and guide evidence-based planning, resource mobilisation and advocacy at national, provincial and district levels. The recent technological developments in data collection and the need for geo-referenced spatial data in planning and programmes have entailed the demand for capacity building in skills, equipment and efficient data systems in line with modern methods of census and survey undertaking. There is need, therefore, for continued support in building capacity in the area of population dynamics to ensure increased generation and, especially, utilisation of data for evidence-based decision making and development planning.

[30] 7th National Population Development Plan 2017-2021
[31] UN Zambia Country Analysis Summary 2015
[32] Ministry of National Development Planning. December 2006. Vision 2030
[33] Central Statistical Office, Population and Demographic Projections 2011-2015, 2013
[34] Ibid
[35] Central Statistical Office, 2010 Census of Population and Housing Analytical Report, 2012
[36] Central Statistical Office, Zambia Population and Demographic Projections 2011-2035
[37] Central Statistical Office, Zambia Demographic and Health Survey Preliminary Report, 2018
[38] Central Statistical Office, 2010 Census of Population and Housing Analytical Report, 2012
[39] Central Statistical Office. Zambia in Figures 2018

2.1.3 Country context and challenges for sexual and reproductive health[40]

At the start of the 8CP the key concerns for sexual and reproductive health (SRH) were described in the UNFPA Country Programme Document for Zambia as: high maternal mortality, despite some decline; continuing high HIV prevalence, particularly in women; and significant unmet family planning needs. In addition, challenges within both the health system and in community support systems were apparent, and obstetric fistula remain a significant problem, as does gender based violence (GBV) including intimate partner violence (IPV).

The maternal mortality ratio remains high (ZDHS 2018 Preliminary Results) at 278 deaths per 100,000 live births, although it has shown substantial decline from 591 deaths per 100,000 live births over the past decade from 2007. Women living in urban areas are more than twice as likely to give birth at a health facility, as compared to women in rural areas. While most deliveries in rural areas (66.5 per cent) were at home, most deliveries in urban areas (79.0 per cent) occurred at a health facility. Skilled birth attendance was estimated at 80 per cent in 2018.

The 2016 Zambia Population HIV Impact Assessment (ZAMPHIA) Report[41] estimated adult HIV prevalence (15-49) at 11.4 per cent, 14.3 per cent in females and 8.3 per cent in males, with the widest gap in the age cohort 20-24. The HIV prevalence gender gap remains wide through the 35-39 age cohort. Incidence in adults aged 15-49 was estimated at 1.1 per cent in females and 0.31 per cent in males (total 0.70 per cent), a slight decline from the previous year. While progress has been made towards the high level 2020 treatment targets of UNAIDS,[42] only an estimated 68 per cent of females and 62 per cent of males were aware of their HIV status, and incidence in women remains unacceptably high.

Overall use of modern contraception has not significantly changed over the past five years.[43] Of currently married women aged 15-49, 45 per cent of married women reported using a modern family planning (FP) method in the 2013/14 ZDHS, and the figure was 48 per cent in 2018. The proportion using injectables has increased, however, from 19 per cent in 2013/14 to 26 per cent in 2018, while the proportion taking the contraceptive pill fell from 12 per cent to 8 per cent. Among sexually active unmarried women, the 2018 ZDHS found that 44 per cent are using an FP method, of which all but 1 per cent are using a modern method. Twenty-one per cent are using injectables, 9 per cent implants, and only 7 per cent condoms for contraception. The total fertility rate remains high at 4.7 per cent,[44] although it has declined from 5.3 per cent in 2013/2014.

The total unmet need for contraception is estimated at 19.7 per cent among currently married women, and varies according to age, educational status, wealth and geographical location. It is higher in women with less education and lower wealth than among women with higher education and wealth, higher in rural areas (21 per cent) than urban areas (17 per cent), and higher in married women aged 40-44 (24 per cent) than in younger age groups. Unmet need is highest in Western Province at 27 per cent, and lowest in Muchinga at 15 per cent. If total demand for FP among married women were met, the contraceptive prevalence rate (modern methods) would increase from the current 48 per cent to 69 per cent.[45]

Intimate partner violence (IPV), including physical, sexual or psychological violence, was estimated to be high at 47 per cent in the 2013/2014 ZDHS,[46] and far more common than non-IPV violence estimated at 10.4 per cent.

Regarding SRH, the overarching Zambia Vision 2030 and the 7th National Development Plan 2017-2021 emphasise strengthened services that particularly address the needs of the most vulnerable and marginalized, strengthened demand and claiming of human rights, and greater gender equality. Several policies and guidelines have been developed to actualise Vision 2030, as indicated in Chapter 4.

2.1.4 Country context and challenges for adolescents and youth[47]

Zambia has a young population, with 65 per cent under age 25, and over half, 52 per cent, under the age of 18.[48] The health and well-being of many is affected by poverty. The most significant challenges young people face, particularly among the

[40] Where possible data are provided from the 2018 Zambia Demographic and Health Survey, ZDHS, but only the preliminary report was available at the time of the CPE. Therefore some data can only be provided from the 2013/14 ZDHS.
[41] https://www.unaids.org/en/regionscountries/countries/zambia
[42] 90% know their status of whom 90% are on treatment, of whom 90% are successfully virally suppressed
43ZDHS 2013/14, ZDHS 2018 Preliminary Results
[44] ZDHS 2018 Preliminary Results
[45] ZDHS 2018 bases this estimate on total demand in married women being 69% and total demand satisfied being 72%, almost entirely through modern methods.
[46] Measured as proportion of ever-partnered women and girls aged 15 and above experiencing IPV in the previous 12 months
[47] UN definitions of age cohorts are: adolescents age 10-19; young people age 10-24; youth age 15-24
[48] CSO (2012) Zambia Census 2010; gender disaggregation for this age group is not readily available but the overall population ratio was 49% male, 51% female

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poor, include early and unintended pregnancy, child marriage, unmet family planning needs, unemployment, poverty, HIV, and gender based violence.[49] Young people often lack access to relevant health information and the skills for risk avoidance, and frequently have limited access to adolescent friendly SRH services.

The 2018 ZDHS estimated the adolescent pregnancy rate at 29.2 per cent, highest in adolescent girls with no education and from the poorest families.[50] Education and wealth correlated strongly with lower rates. Adolescent mothers are more likely to experience adverse pregnancy outcomes, with one in four teens delivering at home.[51] Many also drop out of school. There is also a strong link between unintended pregnancies and unsafe abortions. Also, rates of child marriage are high in Zambia, with 17 per cent of adolescent girls aged 15-19 being in union in 2014.[52] Among adolescent boys of the same age group, only 1 per cent reported being married. There was, however, a decrease in the proportion of 20-24 year old females who reported having been married by age 18 from 42 per cent in 2007 to 31 per cent in 2013-2014.[53]

Among respondents aged 15-49, a larger proportion of men (22 per cent) than women (13 per cent) had never tested for HIV.[54] The likelihood of having ever taken an HIV test and receiving the results of the last test was lowest in the 15-19 age group (59 per cent of women and 46 per cent of men) and in respondents who had never married and never had sex (45 per cent of women and 43 per cent of men). Forty-three per cent of young women and 41 per cent of young men had comprehensive knowledge of HIV prevention. The proportion with comprehensive knowledge generally increased with age and educational attainment.

The transition from adolescence to early adulthood showed a significant increase in HIV infection risk, particularly in girls, HIV prevalence rose from 3.8 per cent of females and 1.8 per cent of males aged 15-19 to 9.6 per cent of females and 3.5 per cent of males aged 20-24.[55] Girls are at greater risk for many reasons from the physiological to age disparate sex and unequal power relations, and discrimination hindering their SRH service access. Comprehensive knowledge of HIV among young people remained low at 43 per cent of females and 41 per cent of males in 2018, less than half the 90 per cent international high level target for 2020, with knowledge of mother to child HIV transmission among 15-19 year olds 62 per cent among females and 44 per cent among males. Respondents aged 15-19 (89 per cent of both women and men) were less likely than those aged 20-49 to know where to seek an HIV test. The likelihood of having ever had an HIV test and receiving the results of the last test was lowest in the 15-19 age group (59 per cent of women and 46 per cent of men) and in respondents who had never married and had never had sex (45 per cent of women and 43 per cent of men).[56]

Approximately 32 per cent of adolescents aged 15-17 and 60 per cent of those aged 18-19 are sexually active in Zambia, and therefore face risks from HIV and other sexually transmitted infections (STIs), especially as only under half report regular condom use.[57] They also experience mental health issues, trauma and physical and sexual violence. In Zambia, approximately 7.2 per cent of sexually active girls (15-19) reported having had a sexual partner who was 10 or more years older in 2013-2014. The 2013-14 ZDHS reported knowledge about obstetric fistula by only 19.2 per cent of adolescents.

In the ZDHS 2013/14, gender based violence was reported by 29.3 per cent of 15-19 year olds, higher among females aged 15-49 who are married (48.4 per cent) compared to 26.5 per cent among those who have never been married. Of adolescent girls aged 15-19, 8.2 per cent had ever experienced sexual violence, defined as a forced sexual act, with 4.2 per cent of these females having experienced sexual violence within the last 12 months. Married adolescents reported significant higher rates of sexual violence at 13.2 per cent. Only 36 per cent of females 15-19 who had experienced physical and sexual violence reported having ever sought help to stop the violence.

Zambia has enacted laws and policies supporting young people's participation in Zambia's development, and a number of policy and strategic documents have been developed including the Adolescent Health Strategy 2017-2021. The GRZ, with support from UNFPA and other cooperating partners, has increased access to overall health and educational services, increased the provision of youth friendly services and safe spaces, enhanced the coverage of comprehensive sexuality education (CSE),

[49] UN Zambia (2015) Zambia Country Analysis Summary
[50] ZDHS 2018
[51] ZDHS 2018
[52] ZDHS 2013/014. Data for this indicator were not available in the preliminary information from the 2018 ZDHS
[53] ibid
[54] ZDHS 2018
[55] Ibid
[56] Ibid
[57] Ibid

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increased and improved family planning services and are increasing fistula repair. However, significant gaps exist in resources, coverage and delivery of services for young people, particularly in rural areas.

2.1.5 Progress towards SDGs and ICPD

The table below highlights the SDG targets and indicators relevant to the UNFPA mandate.

Table 2: Country Progress against SDGs 3, 4 and 5 Relevant to the UNFPA Mandate

Targets and indicators	**Country Achievement**
SDG Goal 3: Ensure healthy lives and promote well-being for all at all ages	
3.1.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births 3.1.2 Proportion of births attended by skilled personnel	278[58] 80% (ibid)
3.3 By 2030 end the epidemic of AIDS 3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations	2016 43,000 pa, incidence 0.61%[59]
3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes 3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods 3.7.2 Adolescent birth rate (10-14 years;15-19 years) per 1,000 females in that age group	68.5%[60] 3; 135[61]
3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all 3.8.1 Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)	Data not available
SDG Goal 4: Ensure inclusive and equitable quality education and promote life-long learning opportunities for all[62]	
4.1 By 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes Primary school net enrolment rate (NER) (MoGE 2017)[63]	87.9%
Proportion of pupils completing primary school (MoGE 2017)	91.8%
Primary to secondary transition rate (MoGE 2017)	67.5%
Secondary school NER (MoGE 2017)	42.9%
Ratio of girls to boys in primary school (MoGE 2017)	1.00
Ratio of girls to boys in secondary school (MoGE 2017)	0.90
4.6 By 2030, ensure that all youth and a substantial proportion of adults, both men and women, achieve literacy and numeracy Literacy rates of 15-24 years (ZDHS 2013/14)	Male 84.9%, Female 77.3%
Literacy level among men aged between 15-49years (ZDHS 2013/14)	83%
SDG Goal 5: Achieve gender equality and empower all women and girls	
5.1 End all forms of discrimination against all women and girls everywhere 5.1.1 Whether or not legal frameworks are in place to promote, enforce and monitor equality and non-discrimination on the basis of sex Report of the Inter-Agency and Expert Group on Sustainable Development Goal Indicators (E/CN.3/2016/2/Rev.1) 8/25 Goals and targets (from the 2030 Agenda)	CEDAW ratified
5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation 5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age 5.2.2 Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence	GBV prevalence rate 47%[64] 10.4% (ibid)

[58] ZDHS 2018 Preliminary Results
[59] ZAMPIA 2016
[60] ZDHS 2018 Preliminary Results
[61] Ibid
[62] Indicators under SDG 4 are complex and detailed, and the table provides the overview of those accessed for Zambia without specific numbering. UNFPA does not directly contribute to SDG 4 indicators but contributes through comprehensive sexuality education, promoting gender equality and equal opportunities for vulnerable people, as well as advocating for investments in education
[63] Ministry of General Education, Educational Statistical Bulletin 2017
[64] ZDHS 2013/14

5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation 5.3.1 Proportion of women aged 20-24 years who were married or in a union before age 15 and before age 18 5.3.2 Proportion of girls and women aged 15-49 years who have undergone female genital mutilation/cutting, by age	5.9%, 31.4% (ibid)

The table below highlights progress in Zambia from 2001/2 to 2018 against selected indicators.

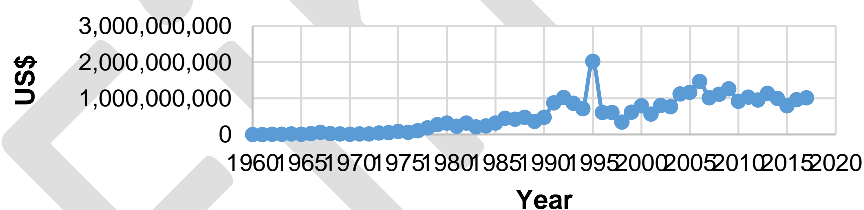
Table 3: Progress on Preventable Maternal Deaths, Total Fertility and Family Planning

Area	ZDHS 2001-2002	ZDHS 2013-2014	ZDHS 2018[65]
Maternal mortality ratio (per 100,000 live births)	729	398	278
Total fertility rate	5.9	5.3	4.7
Modern contraceptive use	25%	45%	48%
Unmet need for family planning	28%	21%	20%

2.2 The role of external assistance

For the years 2016-2017, the latest for which data are available on line,[66] of 10 areas for aid an average of 62 per cent was for health and population. The US government was by far the largest donor at US$ 433 million followed by the Global Fund at US$107 million, the International Development Association at US$ 94 million and the European Union at US$ 73 million. Other donors in order of scale of contribution were Sweden, Japan, Germany, the African Development Fund and France. The figure below indicates the changing levels of Overseas Development Assistance (ODA) for Zambia over time.

Figure 3: Net Overseas Development Assistance and Aid Received (Current US$), 1960-2017, Zambia



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[65] Central Statistical Office, Zambia Demographic and Health Survey Preliminary Findings
[66] http://www.oecd.org/doc/financing-sustainable-development/development-finance-data/aid-at-a-glance.htm

Chapter Three: United Nations/UNFPA Response and Programme Strategies

3.1 United Nations/UNFPA Strategic Response

The global UNFPA Strategic Plan 2014-2017 outlined a strategic direction placing sexual and reproductive health at the centre of the work of UNFPA, with the aim of achieving universal access to sexual and reproductive health and the realisation of reproductive rights, and to reduce preventable maternal mortality. The UNFPA Strategic Plan 2018-2021 maintains this core direction and has adopted the transformative goals of ending preventable maternal deaths, ending unmet need for family planning, and ending gender based violence and all harmful practices (including child and forced marriage) by 2030. The four outcome areas of the UNFPA Strategic Plan 2014-2017 relate to sexual and reproductive health, adolescents and youth, gender equality and the empowerment of women (GEEW), and population dynamics. The subsequent plan has the outcome areas of ensuring that everyone can freely access integrated SRHR services, that young people, especially girls, are empowered to access full SRHR, that GEEW is achieved in development and humanitarian settings, and that all are counted and accounted for with regards sustainable development. Each country is expected to domesticate these outcomes, including the priority of leaving no one behind and reaching the furthest behind first. This orientation has been addressed in the Zambia 8CP as discussed later.

To strengthen transparency, accountability, planning, and communication between partners and stakeholders, the United Nations in Zambia has, in line with delivering as one, brought together all UN projects and activities under the umbrella of the Zambia-United Nations Sustainable Development Partnership Framework (UNSDPF) 2016-2021. This has joint framework results and one joint annual work plan, and no UN projects or activities are intended to take place outside the scope of the jointly agreed outcomes.

3.2 UNFPA Response through the Country Programme

3.2.1 UNFPA Previous Cycle Strategy, Goals and Achievements and Transition to the Current CP

The GRZ-UNFPA 7th Country Programme (7CP) aimed to strengthen reproductive health services and enhance government capacity to implement a multisectoral population programme focused on reproductive health and rights, population and development, and gender equality.[67] It was aligned to the United Nations Development Assistance Framework 2011-2015, the GRZ 6th National Development Plan, the National Population Policy and to other national plans and frameworks, as well as the Millennium Development Goals, ICPD and UNFPA Strategic Framework. The Country Programme Document (CPD) was operationalised in the Country Programme Action Plan 2011-2015, a document that UNFPA globally has since discontinued. Although there was no mid-term review or end evaluation of the 7CP, the 8CPD highlights achievements of the 7CP in all three thematic areas and utilising all five modes of engagement (advocacy and policy dialogue, knowledge management, capacity development, service delivery and partnerships and coordination), but without specific quantification of achievements.[68] Indicative resources for the 7CP were US$ 20 million, which included US$ 16 million in regular resources and US$ 4 million in other resources. The 7CP included: six interventions under reproductive health and rights (e.g. strengthening EmONC in rural health facilities, including through staff training, and integrating SRH/HIV services), four under gender equality (e.g. advocacy support for the national gender policy, and capacity development of key institutions to research and respond to GBV): and four under population and development (e.g. building technical capacity at national and provincial levels to utilise population data in strategies and plans). Noted concerns that are addressed further in the 8CP were the need to strengthen SRH/HIV/GBV programme integration, ensure reach to rural and under-served areas, and to empower women and young people to utilise services. Lack of out of school curricula for SRHR and non-inclusion of SRHR in in-school curricula for grades 5-12 were also noted and, regarding population and development, the main concern was the need to capacitate provincial and district data management systems.

The 8CPD also indicated two key lessons learned from the 7CP that have particularly influenced the development of the current cycle. First was the need to strengthen well-coordinated multi-sectoral partnerships with government and civil society to address socio-economic drivers of teen pregnancy, child marriage and total fertility rates. Second was the need to

[67] UNFPA (2010) Country Programme Document for Zambia
[68] UNFPA 8th Country Programme Document for Zambia

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mainstream gender and HIV as cross-cutting components of SRH to strengthen programme results given the correlation between HIV transmission, gender inequality and poor outcomes in sexual and reproductive health.

The overall direction of the 8CP builds on the achievements of the previous CP with no major shifts except in emphasis. Gender mainstreaming intends to promote GEEW throughout the programme as opposed to maintaining it as a separate thematic area. The addition of a specific thematic area on adolescents and youth reflects the particular importance of addressing indicators such as teen pregnancy and the wider SRH needs of this cohort, particularly among marginalized girls, in the context of a young population age structure. The table below highlights the outputs of the 7CP and the 8CP, showing the main changes and developments.

Table 4: 8CP and 7CP Outputs and Programme Component Areas

8th Country Programme (2016-2020)	7th Country Programme (2011-2015)
Programme Area: Sexual and reproductive health (a human rights approach is now integrated across all SRH including HIV and GBV)	**Programme Area: Reproductive health and rights**
Output 1: National, provincial and district institutions have increased capacity to deliver gender-sensitive sexual and reproductive health and HIV services Output 2: National, provincial and district institutions have the capacity to increase demand for and improve supply of life-saving reproductive health commodities and medicines, including modern contraceptives	Output 1:Increased availability of integrated reproductive health services, particularly family planning, antenatal and post-natal care, adolescent-friendly health services, and essential and emergency obstetric and neonatal care Output 2: Increased availability of HIV/AIDS prevention services Output 3 Improved reproductive health commodity security
Programme area: Adolescents and Youth	Not a programme area: **incorporated in SRH**
Output 1: Increased capacities of national, provincial and district institutions to design, implement and monitor comprehensive sexuality education programmes that promote human rights and gender equality Output 2: Increased capacity of national, provincial and district institutions to design and implement comprehensive programmes for marginalized adolescent girls, including safe spaces, for those at risk of child marriage	
Programme Area: Population Dynamics (narrower than population and development)	**Programme area: Population and Development**
Output 1: Increased availability of disaggregated evidence through cutting-edge data generation and in-depth analysis of population dynamics, sexual and reproductive health, HIV, and gender-equality outcomes	Output 1: Strengthened institutional and technical capacity to support the implementation, monitoring and review of the national population policy Output 2: Increased availability and use of policy-relevant and disaggregated population data at all levels, and research results for evidence-based policy formulation and implementation
Not a programme area: **gender mainstreamed across all areas**	**Programme area: Gender Equality**
	Output 1: Strengthened capacity of the Government and non-governmental organizations to implement, review and revise gender policies, programmes and action plans Output 2: Effective mechanisms to address gender-based violence, gender inequality and discrimination, and the empowerment of women

The 8CP has, in addition, mainstreamed attention to people with disabilities, and the realisation of human rights, in line with the principles and goals of the SDGs. The strategic response of UNFPA is also guided by the UN Division of Labour, especially in relation to HIV and AIDS.

3.2.2 Current UNFPA Country Programme

The 8CP was grounded in the principles of the International Conference on Population and Development (ICPD) Programme of Action, and by the Sustainable Development Goals 2016-2030, notably SDG 3 on health and well-being and SDG 5 on gender equality and the empowerment of women and girls. The global UNFPA Strategic Plan (2014-2017) guided the

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development of the GRZ-UNFPA 8CP and this was later revisited in line with the UNFPA Strategic Plan 2018-2021 through an alignment process finalised in January 2018 (document review, CO interviews). Within the international framework, the 8CP responds to national priorities as articulated in the Seventh National Development Plan (7NDP). Chapter 4 EQ 1 on relevance elaborates further on the 8CP international and national alignment. Women and young people, especially adolescent girls and young women, are the primary beneficiaries of UNFPA, with addressing their SRHR needs enabled by respect for human rights, gender equality, and population dynamics.

Regarding the UNSDPF, GRZ and the UN agreed on eight outcomes under three broad results pillars. Outputs are agency specific, and the results matrix of the Partnership Framework includes outcomes and their measurement. The 8CP contributes principally to addressing Framework indicators on: the proportion of births attended by skilled health personnel under outcome 1.1 on improved social services; the modern contraceptive prevalence rate in women of reproductive age (15-49); proportion of adolescents age 15-24 receiving HIV test results in the past 12 months, and the percentage of women aged 25-49 married before age 18, under outcome 1.2 on demand for integrated social services; percentage of satisfied users of data provided by the National Central Statistical Office System under outcome 3.2 on data for evidence-based national development; and to the Gender Inequality Index under outcome 3.3 on equitable participation in democratic processes. Chapter 4, EQ 5 elaborates further on how the UNSDPF reflects the priorities and mandate of UNFPA.

According to the UNFPA Strategic Plan 2018-2021 Business Model, Zambia, like most of sub-Saharan Africa, is classified in the red quadrant (most at risk) because of the extent of needs and the level of government financial capacity; all five modes of engagement apply[69] to address key milestones. The milestones cut across all three thematic areas of sexual and reproductive health (SRH), adolescents and youth (AY), and population dynamics (PD), and also relate to cross-cutting issues of human rights and gender (for instance regarding GEEW and child marriage).

The 8CP Results Framework (Table 5 below) includes two outputs each for SRH and AY, and one for PD. To achieve the outputs UNFPA works at national and sub-national levels. At national level, UNFPA is engaged in: advocacy and support for policies and programmes to advance sexual and reproductive health and rights (SRHR) including for comprehensive sexuality education; reproductive health commodity procurement and strengthening supply chain management systems; institutional capacity development; and data generation and analysis to inform development policies strategies, standards and programmes for SRH and wider development issues. At sub-national level, in the 8CP UNFPA has supported selected districts in seven provinces out of 10[70] to strengthen SRH systems and services. This includes: ongoing support for integrated and strengthened SRH, HIV and GBV services, and for adolescent friendly health services in three provinces (Luapula, North-Western and Western), where UNFPA has sub-offices; joint DfID/UN support for Central and Western Provinces as part of GRZ health systems strengthening (HSS) through a joint UN RMNCAH&N[71] programme; a UNFPA-UNICEF joint programme to end child marriage in Eastern Province; and a GRZ, EU, UN joint Millennium Development Goals Initiative (MDGi) in the Copperbelt and Lusaka Province.

In the 8CP UNFPA has provided technical and/or financial support to 13 implementing partners (IPs) including GRZ line ministries, notably the ministries of Health and four provincial health offices,[72] National Development Planning, Chiefs and Traditional Affairs, and Youth, Sports and Child Development, the Central Statistical Office, and several non-government organisations (NGOs): Population Council of Zambia, Planned Parenthood Association of Zambia (PPAZ), Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS), and the Young Women's Christian Association of Zambia (YWCA). It will shortly engage in programming around family planning with the main IP to be confirmed in late 2019. UNFPA also has key partners in other ministries (for gender, education and finance), in the UN (UNICEF, UNAIDS, WHO, UNDP, IOM, ILO), the University of Zambia and the National Assembly, and locally based development cooperation partners of DfID, Sweden and the EU (CO presentation, document review). The full list of Atlas projects is annexed.

[69] Advocacy and policy dialogue, capacity development, knowledge management, service delivery, partnerships and coordination
[70] Four districts out of 12 in Luapula, and four out of 11 in North-Western; all 12 in Central and all 16 in Western Province.
[71] Reproductive Maternal, Neonatal, Child, and Adolescent Health and Nutrition
[72] Provincial health offices in Central, Luapula, North-Western and Western provinces.

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Table 5: 8CP Results Framework 2016-2020

National priority: To become a prosperous middle-income country by enhancing human development and investing in social sectors
United Nations Sustainable Development Partnership Framework (UNSDPF) outcomes: By 2021, the Government of Zambia and partners deliver equitable, inclusive, quality and integrated basic social services; marginalized and vulnerable populations demand and utilize quality and integrated basic social services; and all communities practice sustained positive behaviour

UNFPA strategic plan outcome	Country programme outputs	Output indicators, baselines and targets	Interventions Areas
Outcome 1: Sexual and reproductive health Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access Outcome indicators: ➢ Contraceptive prevalence rate for modern methods *Baseline: 45%; Target: 58%* ➢ Unmet need for family planning *Baseline: 21%; Target: 14%* ➢ Percentage of births attended by skilled health personnel *Baseline: 64%; Target 75%* ➢ Proportion of women and men with more than two partners in last 12 months reporting condom use *Baseline: 29.7% women and 27.4% for men; Target: 50% for both women and men* ➢ Percentage of young people aged 15-19 years counselled and tested for HIV and received results *Baseline: 28% male and 47% female*; *Target: 65% male and 85% female*	Output 1: National, provincial and district institutions have increased capacity to deliver gender-sensitive sexual reproductive health and HIV services	➢ Number of national guidelines with quality of care protocols available for the provision and monitoring of integrated sexual reproductive and HIV services *Baseline: 9; Target: 12* ➢ Number of health facilities providing quality emergency obstetric care services in supported provinces *Baseline: 250; Target: 400* ➢ Percentage of health-care providers with capacity to deliver quality, gender-sensitive sexual reproductive and HIV services in supported provinces *Baseline: 58; Target: 90* ➢ Number of fistula repair surgeries conducted in supported provinces *Baseline: 1,786; Target: 3,800*	➢ Capacity development for health care providers on integrated SRH/HIV/GBV ➢ Evidence-based advocacy for SRH/HIV/GBV ➢ Institutionalization of fistula management ➢ Piloting integrated SRH and HIV service delivery models ➢ Integrated minimum service package in humanitarian settings ➢ Evidence-based and innovative demand creation interventions ➢ Multi-sectoral coordination mechanisms
	Output 2: National, provincial and district institutions have capacity to increase demand for and improve supply of life-saving reproductive health commodities and medicines, including modern contraceptives	➢ Number of public health facilities with at least seven life-saving reproductive health medicines and commodities in supported provinces *Baseline: 150; Target: 350* ➢ Number of male and female condoms procured and distributed per year *Baseline: 34 million male and 1 million female; Target: 61.4 million male and 2.6 million female* ➢ Number of health-care providers with capacity to deliver a method mix of family planning services in supported provinces *Baseline: 500; Target: 1,000* ➢ Number of new acceptors of modern contraceptives per year in supported provinces *Baseline: 500; Target: 750*	➢ Evidence based advocacy for increased domestic funding for RH commodity needs and ➢ Procurement of modern contraceptives and life-saving maternal health medicines for public sector ➢ Capacity development for evidence-based forecasting, quantification, logistics and supply chain management systems ➢ Improved delivery of quality family planning services to marginalized population groups and underserved communities
Outcome 2:Adolescents and youth Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health Outcome indicators: ➢ Proportion of provinces implementing rights-based, comprehensive sexuality	Output 1: Increased capacity of national, provincial and district institutions to design, implement and monitor comprehensive sexuality education programmes that promote human rights and gender equality	➢ Number of national laws and policies that promote access to gender-sensitive and rights based adolescent sexual reproductive health information and services *Baseline: 0; Target: 2* ➢ Number of provinces with capacity to deliver quality youth-friendly health services that are aligned with international standards *Baseline: 5; Target: 10*	➢ Design and delivery of innovative out-of-school CSE programmes ➢ Incorporation of gender sensitive and human rights components for in-school CSE curricula ➢ National and provincial level policy coherence and multi-sectoral coordination for youth health and development programmes

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education programmes for in and-out of school youth *Baseline: 0; Target: 3* ➢ Proportion of provinces denouncing ending child marriage practices *Baseline: 4; Target: 8*	Output 2: Increased capacity of national, provincial and district institutions to design and implement comprehensive programmes for marginalized adolescent girls including safe spaces for those at risk of child marriage	➢ Number of community-based organizations with capacity to design and implement safe spaces programmes for marginalized adolescents *Baseline: 4; Target: 20* ➢ Number of community leaders leading community-based social and economic assets - building programmes to reach girls at the risk of child marriage *Baseline: 20; Target: 50*	➢ Implementation and monitoring of national strategies and community-based Ending Child Marriage related programmes ➢ Strategic partnerships to build social and economic assets of vulnerable women and adolescent girls ➢ Design and use of accountability mechanisms that enforce legislative and policy actions on legal age of marriage
United Nations Sustainable Development Partnership Framework (UNSDPF) outcomes: By 2021, national statistical systems generate and disseminate disaggregated evidence for national development processes; national institutions at all levels target, manage, coordinate and account for resources for equitable service delivery and economic growth that is based on reliable data; Zambia promotes equitable and effective participation in national and democratic processes, especially by women, youth and marginalized groups			
Outcome 4: Population dynamics Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality Outcome indicator(s): ➢ Proportion of national statistical publications with disaggregated data on sexual reproductive health by age, sex and wealth quintiles *Baseline: 3; Target: 6* ➢ Number of national development plans and sector policies incorporating population dynamics *Baseline: 6; Target: 10*	Output 1: Increased availability of disaggregated evidence through cutting-edge data generation and in-depth analysis of population dynamics, sexual and reproductive health, HIV and gender equality outcome	➢ Number of provinces with capacity to collect , analyse and use disaggregated data to inform plans, policies and programmes *Baseline: 0; Target: 6* ➢ Number of monographs and in-depth analysis reports generated with disaggregated data sets for sexual reproductive health, including in humanitarian preparedness and response *Baseline: 5; Target: 15*	➢ Capacity development for national, provincial and district level institutions ➢ Evidence-based advocacy for integration of population variables into national plans and policies ➢ Empowering women and young people with capacities to engage in evidence-based advocacy, policy dialogues and development processes

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3.2.3 The Country Programme Financial Structure

The CP was approved in June 2015 with proposed UNFPA assistance of US$ 36 million allocated as below.

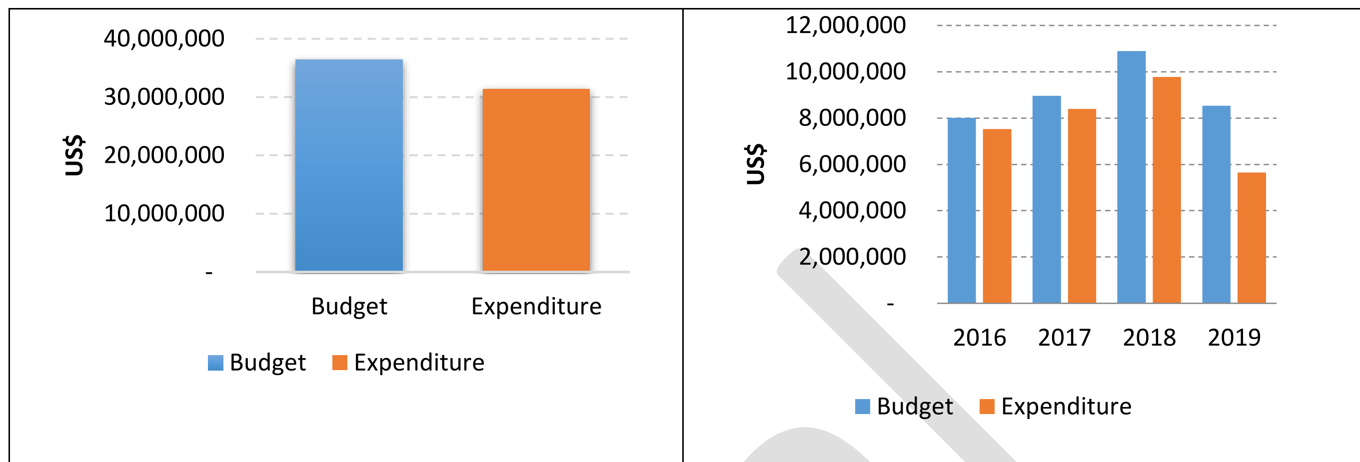
Table 6: Proposed Indicative Assistance in Millions of US$

Strategic plan outcome areas		Regular resources	Other resources	Total
Outcome 1	Sexual and reproductive health	8.6	11.1	19.7
Outcome 2	Adolescents and youth	4.9	3.6	8.5
Outcome 4	Population dynamics	2.8	4.4	7.2
Programme coordination and assistance		1.4	-	1.4
TOTAL		**17.7**	**19.1**	**36.8**

This is a significant increase from the US$ 20 million indicative assistance for the 7CP, which included US$ 16 million in regular resources and US$ 4 million in other resources. The fgures below indicate the actual total budget against expenditure,

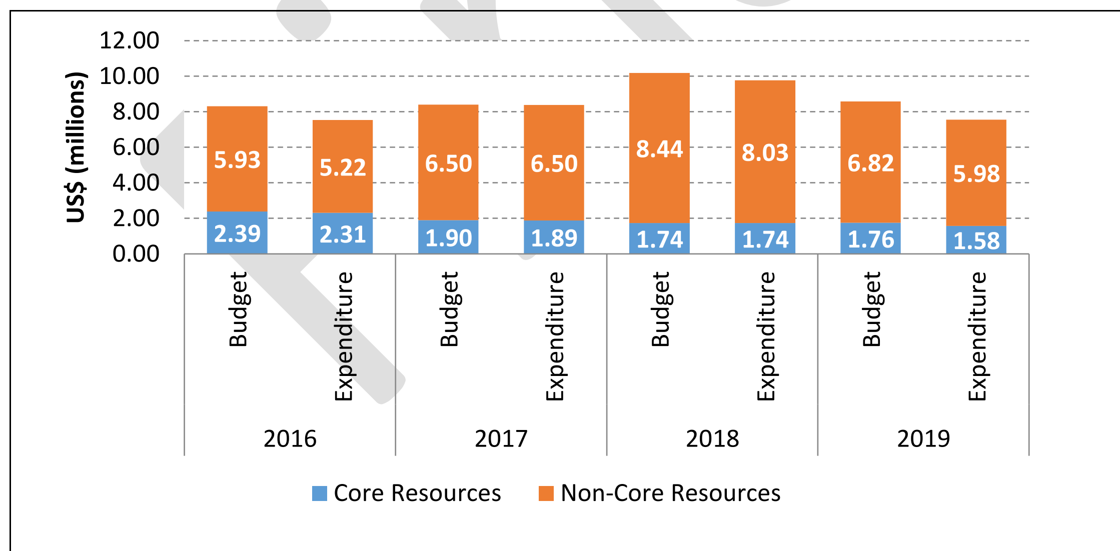
the evolution of budget and expenditure over the CP, and funding by year and funding source. Total regular (core) resources from UNFPA HQ were less than half the indicative budget, and declined during the CP. This reflects the declining availability of core funds within UNFPA globally for country support. However, the CO was highly successful in raising non-core resources substantially beyond the indicative amount.

Figure 4 and Figure 5: Total Funding against Expenditure, and Evolution from 2016-2019



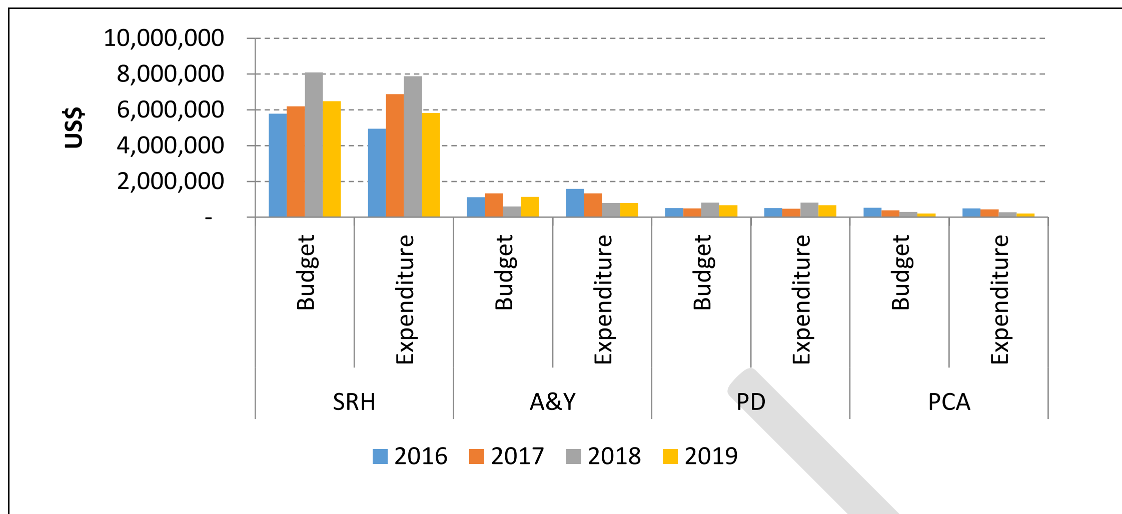
Core resources primarily cover programme coordination assistance, such as staffing, and also population dynamics, but otherwise most programme funding comes from non-core resources mobilised for specific programme areas (document review and CO interview). Figure 6 reflects the very high dependence on resource mobilisation for programming.

Figure 6: Budget and Expenditure by Origin of Funds, 2016-2019



Budget and expenditure by year by thematic area and for management is indicated below. This indicates high overall budget utilisation rates (all over 90 percent except for slight under-spend (86 percent) on SRH in 2016, and slight over-spend on management in 2017, and more significantly on adolescents and youth in 2016 and 2018. In 2018 funding for this thematic area was significantly reduced with the ending of DfID Zambia funding to end child marriage. Lower levels of funding have continued into 2019 for adolescents and youth, with non-core resources. The funding sources (regular resources/other resources) of all Atlas projects are provided in Annex 4, with the full budget and expenditure by project accessible through the link provided in the Annex.

Figure 7: Budget and Expenditure by Thematic Area and by Year 2016-2019[73]



Clearly the sexual and reproductive health thematic area has by far the highest budget and expenditure. The adolescents and youth thematic area has a much smaller budget that arguably should be greatly increased in line with the critical importance of this focus (KI interviews and document review). Nonetheless, the SRH thematic area does include various interventions, such as integrated SRHR/HIV services and RMNCAH&N that include significant components addressing young people. In effect, the two areas overlap and, in the previous CP, were addressed as one thematic area. All interventions are available in the annexed Terms of Reference with the full Results Framework, and their level of achievement is addressed in response to questions on effectiveness in Chapter 4.

As well as the above, as part of DaO, the UNSDPF has developed a Common Budgetary Framework (CBF) to outline the time, people, skills and funding resources required to deliver the strategic outcomes of the partnership. Each agency draws up those areas of the CBF that fall within its mandate and comparative advantage. In addition, a Partnership Framework Investment Plan accompanies the CBF to promote an approach that can lead to a transformative impact, with each stage catalysing the next. Each agency leverages its existing funding partnerships, and the indicative total resources to achieve results are US$ 806 million (excluding resources from the International Fund for Agricultural Development).

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[73] Sexual and Reproductive Health, adolescents and youth, population dynamics, programme coordination assistance

Chapter Four: Findings

4.1. Relevance

4.1.1 To what extent is the UNFPA country programme (CP) aligned with the goals of the ICPD Programme of Action, SDGs and the strategies of UNFPA, and adapted to: national needs, policies and development plans; priorities of the programme stakeholders and priority groups, particularly the vulnerable and marginalized (such as young people with disabilities)?

Summary

The 8CP is fully aligned to international development priorities and is relevant and responsive to national needs. It is well aligned to the ICPD Programme of Action, SDGs (especially 3 and 5) and to the strategic plans of UNFPA. It is also well aligned to the key national development plans of GRZ with respect to sexual and reproductive health and rights, adolescents and youth, population data, gender issues and leaving no-one behind. The CPE is fully aligned to specific national policies and strategies in the thematic programme areas, and UNFPA has contributed to several policies, strategies and guidelines in this and in previous CPs.

Addressing gender inequality, empowerment of women and gender based violence (GBV) have continued to be a priority focus, mainstreamed across thematic areas. Upholding human rights also underlies the 8CP but could be further developed, including with respect to people with disabilities and key populations (e.g. sex workers), and the adoption of rights based language.

The population dynamics focus has addressed sub-national data needs as well as supporting key national surveys, a development greatly appreciated by implementing partners.

4.1.1.1 Strategic Level

The GRZ-UNFPA 8th Country Programme (8CP) is fully aligned with the International Conference on Population and Development (ICPD) Programme of Action, with the 2030 Agenda for Sustainable Development Goals (SDGs) and with global UNFPA strategic positioning, as well as with national priorities expressed in Vision 2030 and the 7th National Development Plan (7NDP), and in sectoral policies, plans and priorities.

The CP is closely aligned to the ICPD Programme of Action[74] in many areas, notably with regards: sexual and reproductive health and rights (SRHR), including family planning, HIV and STI prevention; gender equality and empowerment of women (GEEW); safe motherhood; with the focus on adolescents, especially girls; with data for population and development; and with related human capital development and financial resource mobilisation.

With regards the SDGs, as noted in Chapter 3, the main alignment of the 8CP is with SDG 3 on health and SDG 5 on gender equality, with further alignment to SDG 4 on education and also to an extent with SDG 17 on partnerships (with a particular focus on data). Within SDG 3 the 8CP focus includes: improving maternal death surveillance and skilled birth attendance (facility based delivery with trained midwives) to reduce maternal deaths; HIV prevention; strengthened family planning, and reducing adolescent pregnancies; and increasing universal health coverage (in relation to integrated SRH, HIV and GBV and also fistula). Within SDG 5, the 8CP focuses primarily on gender based violence (GBV), child marriage, women's informed decision making on SRH and family planning, and laws and regulations regarding women's access to SRHR (including for adolescents). Indirectly UNFPA contributes to SDG 4 on education, in the support for comprehensive sexuality education, gender equality and inclusion of vulnerable groups, and promoting investment in education and training. The focus on SDG 17 lies in supporting the generation, dissemination and utilisation of disaggregated population data for development including for the Zambia Demographic and Health Survey 2018 and the census in 2020.

The UNFPA Strategic Plan (2014-2017) reaffirmed the strategic direction that placed sexual and reproductive health and rights (SRHR) at the centre of the work of UNFPA, with the 'bull's eye' illustrating its central goal. This goal is to achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce preventable maternal mortality in line with the ICPD agenda and Programme of Action. To attain this goal, the work of the organization was centred on an enhanced focus on family planning, maternal health, and HIV and AIDS. Reaching this goal would also make a major contribution to the Millennium Development Goals (MDGs). Women and young people, especially adolescent girls and young

[74] International Conference on Population and Development 1994 Summary of Programme of Action http://www.partners-popdev.org/icpd/ICPD_POA_summary.pdf

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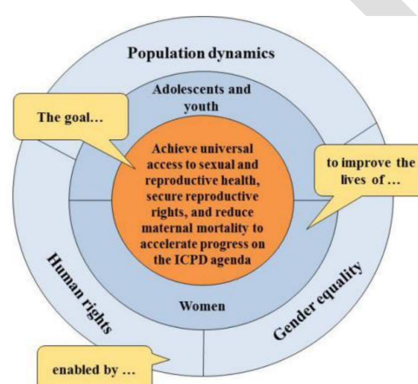
women are the key beneficiaries of UNFPA, with achievement of the goal enabled by respect for human rights, gender equality, and population dynamics.

To align with the 2030 Agenda for Sustainable Development Goals, in 2017 UNFPA introduced the UNFPA Strategic Plan (SP) 2018-2021 with the same 'bull's eye' goal as the UNFPA Strategic Plan 2014-2017. The current plan has three transformative and people-centred results for 2030: ending preventable maternal deaths; ending the unmet need for family planning; and ending gender based violence and all harmful practices, including female genital mutilation and child, early and forced marriage. The 8CP is also effectively aligned to the 2018-2021 UNFPA SP that continues the core emphasis of the previous plan with respect to the bull's eye. An alignment process to the new SP was undertaken in 2018 and fully integrated (CO interviews and document review). The CO mapped the 8CP to the corresponding SP outcomes, outputs and indicators while ensuring that the CO is still able to track progress towards 8CP results through measurable milestones. The alignment to the new SP is also reflected in IP work plans and SIS. As of 2018, the CO reports progress against the new SP outcomes, outputs and indicators.

Figure 8: The UNFPA Bull's Eye



The 8CP is well adapted to national needs, policies and development plans, and the priorities of stakeholders and priority groups. Vision 2030,[75] the overarching long-term aspiration of GRZ, has as the central goal of achieving a prosperous middle-income nation by 2030, with greatly reduced inequalities and poverty and including, among many other aims, achieving equitable access to quality health care and education for all. The 7NDP 2017-2021[76] is guided by Vision 2030, and many sectoral policies are in place to guide planning and programming as indicated in the sections below. The 7NDP aims to 'Accelerate Development Efforts towards Vision 2030 without Leaving Anyone Behind'. The Ministry of National Development Planning (MNDP) coordinates the 8CP, which operates in conjunction with other direct line ministries as indicated in the following sections, and links with Ministry of Finance.

Document review indicates that the 7NDP is well aligned with the SDGs and the UNFPA mandate is aligned to the 7NDP regarding: reducing gender inequalities; reducing developmental inequalities, particularly regarding rural poverty and including strengthening health services; and human capacity development. The National SDGs Baseline Report was due shortly after the CPE, addressing the GRZ indicators to measure progress on the SDGs.

The 8CP has continued to utilise all five modes of engagement (advocacy and policy dialogue, capacity development, knowledge management, partnership and coordination, and targeted service delivery) to achieve its objectives. All are highly relevant in the context of Zambia as a lower middle income country (LIMC) that still faces severe inequalities, widespread poverty, and inadequate infrastructure and capacity in the health and other sectors. In the longer term, UNFPA may need to reduce the focus on direct service delivery and increase the emphasis on the higher levels of engagement, in line with expectations of an LMIC. However, at the time of the CPE an unintended consequence of this transition would likely be a negative effect on service delivery.[77]

[75] GRZ (2006) Vision 2030.
[76] Ministry of National Development Planning 7th National Development Plan 2017-2021 (Volume I) and Implementation Plan (Volume II)
[77] Particularly given high national debt and the allocation of just 9% of the budget to health (well below the 15% Abuja Declaration minimum)

The Zambia-United Nations Sustainable Development Partnership Framework (UNSDPF) 2016-2021 provides the overarching focus of UN support to the GRZ in line with identified national priorities,[78] and clearly reflects the priorities and mandate of UNFPA (see EQ 5). In order to align strategically with the 7NDP and the Partnership Framework, UNFPA is extending the 8CP to 2021 from the original time frame of 2016-2020. Mid-term review (MTR) of the Partnership Framework[79] did not find any need for strategic change in orientation, given that the development priorities of the GRZ remain relatively unchanged. This implies that the focus for UNFPA also remains highly relevant.

4.1.1.2 Sexual and Reproductive Health including Adolescents and Youth

The contributions of UNFPA towards sexual and reproductive health, adolescents and youth have been highly relevant and responsive to the needs of the GRZ at the levels of policy, strategy and guideline development, knowledge management, capacity development in the health sector, support for service provision, awareness and demand creation and reproductive commodity supply. The Ministry of Health (MoH) is the core line ministry with which UNFPA works at both national and sub-national levels for SRH. The SRH focus of UNFPA is fully aligned and responsive to the priority needs of GRZ, building on commitments and support from previous CPs and new policies and guidelines in the 8CP. These include UNFPA technical and/or financial contributions to the National Health Strategic Plan 2017-2021, National HIV and AIDS Strategic Framework 2017-2021, the Road Map for HIV Prevention 2017-2021 and its indicator and target framework, and National Guidelines for Sexual and Reproductive Health, HIV and GBV Services Integration 2015 among many others (see annexed list of documents reviewed and EQ2). Of particular importance is the alignment of the 8CP to gender policies and plans through mainstreaming gender equality and empowerment of women and girls and addressing GBV across thematic areas. Notably the CP is aligned to the Anti-Gender Based Violence Act of 2011, the GBV National Guidelines of 2011, and the 2014 National Gender Policy. The 8CP is actively engaged in integrated SRH, including for young people, within these policies and frameworks.

In support of GRZ SRH policies in 2017, UNFPA commissioned the Population Council to develop a series of five briefs for parliamentarians and policy makers, including: adolescent pregnancy; child marriage; FP and preventing unsafe abortion, post-abortion care and maternal health; comprehensive sexuality education and adolescent SRH; and violence against women and HIV prevention and AIDS treatment. These were produced and widely circulated, increasing access to and knowledge of these core issues among key stakeholders (document review, KI interviews).

In line with leaving nobody behind, UNFPA selected provinces and districts for support based on poverty and poor SRHR indicators (KI interviews, document review). Adults and young people with disabilities are also acknowledged as vulnerable populations in Zambia national documents, and UNFPA is beginning to address their needs (although much more is needed). This is elaborated in EQ2. With regards GEEW and GBV, programmes are mainstreaming gender through sensitization of provincial, district and health staff, and support for one stop centres (OSCs) among other initiatives, also elaborated in EQ2. During field work the findings from KI interviews and focus group interviews with primary beneficiaries, or rights holders (women, adolescents and youth, particularly girls) and secondary beneficiaries (duty bearers and gate keepers who were trained and/or sensitised) were unanimously positive about the relevance and importance of UNFPA support.

The 8CP adolescent and youth component contributes to the priorities of: the Ministry of Health regarding young people's sexual and reproductive health; the Ministry of Youth, Sports and Child Development (MoYSCD) with respect to interventions with young people aged 10-24; the Ministry of Gender (MoG) regarding child marriage, a multi-sectoral focus that the MoG coordinates; the Ministry of General Education (MoGE) regarding comprehensive sexuality education; and the Ministry of Chiefs and Traditional Affairs (MoCTA), which coordinates all issues to do with culture and tradition, including with regards changing patriarchal attitudes, and to adolescent and youth access to SRH information and services. The 8CP focus on these areas is highly relevant to expressed national needs as indicated in the Adolescent Health Strategy 2017-2021 of the MoH, to which the CO contributed. This includes a focus on adolescent SRH, HIV, GBV, alcohol and substance abuse that are often linked with riskier behaviours, and adolescents with special needs, all areas to which UNFPA contributes. UNFPA support is also aligned to the National Youth Policy 2015, and the MoG National Strategy on Ending Child Marriages 2016-2021 and its related advocacy and communication strategy,[80] to both of which UNFPA also contributed and for which it has a strong programming focus. Other policies and plans to which the CP is aligned specifically regarding young people include: the

[78] UN Zambia Policy Group (2015) Zambia Country Analysis
[79] Mid-Term Review of the Zambia-UN Sustainable Development Partnership Framework 2016-2021
[80] Ministry of Gender (2016), Movers and Models for Ending Child Marriage in Zambia, National Advocacy and Communication Strategy on Ending Child Marriage in Zambia 2018-2021

action plan on youth empowerment,[81] curricula for empowerment of girls[82] and training boys and young men,[83] the education and skills sector plan (that includes HIV, GBV and disability as cross-cutting issues)[84] and adolescent and youth aspects of the gender policies and strategies noted earlier. Given the youthful population of Zambia (65 per cent aged under 25 and 52 per cent aged under 18),[85] GRZ places a high priority on realising the demographic dividend, thus the inclusion of adolescents and youth as a specific thematic area in the 8CP is a responsive and relevant development from the 7CP. In 2018 UNFPA successfully commissioned Population Council to produce a policy brief on the state of youth in Zambia. This has raised awareness among parliamentarians, policy makers and other stakeholders of the extent of issues facing young people and aims to promote greater investment.[86]

The Health National Adaptation Plan of 2019, developed with financial and technical inputs from the UN Joint Program and UNDP does not specifically mention SRHR. It does acknowledge, however, the urgent need to reduce population growth in line with Vision 2030, health systems strengthening and increasing access to health services, areas to which UNFPA is contributing with regards SRHR. There is also a focus on the needs of young people given their numbers and the need to assure their future to build the Zambia to which Vision 2030 aspires. The related National Human Resources for Health Strategic Plan 2018-2024, to which UNFPA contributed, includes building human resources of doctors, nurses and midwives, the core of UNFPA support, with emphasis on serious rural shortages.

One concern, with respect to leaving nobody behind and reaching the most vulnerable, relates to priority populations of sex workers, men who have sex with men (MSM) and transgender persons, for whom UNFPA is co-convenor with UNDP in the UN 2018 Division of Labour. Insufficient data are available on these populations despite their having typically far higher HIV incidence and prevalence than the general population. The legal and social environment are not enabling, however. UNFPA contributed to the National AIDS Strategic Framework (NASF) 2017-2021 and the aligned HIV Prevention Road Map 2017-2021, both of which reflect their needs and express national commitment to meet the 2020 high level, fast-track targets on AIDS, HIV prevention and discrimination. Although one integrated joint programme on SRHR does include key populations, UNFPA has not been extensively involved during the 8CP in their support beyond at the overarching political and planning level (KI IP and CO interviews and document review), and the CPE notes this as a partial gap.

4.1.1.3 Population Dynamics

The population dynamics component of the 8CP is aligned to the ICPD Programme of Action and the strategies of UNFPA. It is also aligned to Zambia-United Nations Sustainable Development Partnership Framework (2016-2021) through Pillar 3: Governance and participation regarding Outcome 3.1 on the national statistical system that generates and disseminates disaggregated data for evidence-based national development processes.[87] The component relates to the Zambia's Sustainable Development Goals Coordination and Implementation Framework (2017-2030)[88] and is also well aligned to Zambia's 7NDP 2017-2021 (Volume I) and its Implementation Plan (Volume II) on population and development. The 8CP aligns fully to the National Population Policy[89] objectives on the integration of population issues into all development planning processes, and the harnessing of the demographic dividend. The population dynamics component is, therefore, well aligned to the data needs for evidence-based decision-making, policy-making and development plans for sexual and reproductive health and rights, adolescents and youth, HIV and gender equality at national and sub-national levels.

UNFPA provided technical and financial support for in-depth studies at national and sub-national level of SRHR, adolescents and youth, and for HIV and gender equality, as well as data relevant to wider development priorities. These data have contributed substantially to the evidence base for policy dialogue and advocacy (KI interviews and document review).

UNFPA financial and technical support included capacity development of human and other resources in the Central Statistical Office to prepare for the 2020 census, support for critical surveys such as the Zambia Demographic and Health Survey of 2018, and support to generate disaggregated geo-referenced data at sub-national level that needs further dissemination and

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[81] Ministry of Youth, Sports and Child Development (2015) An Action Plan for Youth Empowerment and Employment
[82] UKAID/Population Council/YWCA, Adolescent Girls Empowerment Programme - Health and Life Skills Curriculum
[83] Zambia YWCA/UNFPA Working with Boys and Young Men Training Curriculum
[84] Ministry of General Education and Ministry of Higher Education (2017) Education and Skills Sector Plan 2017-2021
[85] Zambia Demographic and Health Survey 2018
[86] Population Council/UNFPA (2018) State of the Youth in Zambia Policy Brief: Education, Unemployment and Poverty Reduction
[87] Zambia-United Nations Sustainable Development Partnership Framework (2016-2021)
[88] Ministry of National Development Planning and United Nations-Zambia. 2018. Zambia SDGS Coordination and Implementation Framework 2017-2030
[89] Ministry of National Development Planning. 2019. National Population Policy

utilisation (KI interviews with IPs and the CO and document review). All are highly relevant for evidence-based policy and planning. In particular, UNFPA technical and financial support for sub-national in-depth analysis of key socio-economic indicators to the lowest geographical level has been highly appreciated (KI interviews).

Implementing partners for PD consistently confirmed that UNFPA technical and/or financial support was relevant to their needs and priorities, as the priorities were agreed in joint annual work plan meetings and relate to known GRZ concerns for development (KI interviews and document review). IPs (KI interviews) noted that, with the approval of the revised National Population Policy that will provide the overarching policy framework for all sectors, there will be need to strengthen support in the integration of population variables in development plans. Thus the technical and financial support of UNFPA for population data will continue to remain highly relevant, as discussed further in EQ2.

4.1.2 To what extent has the country office been able to respond to changes in national and provincial needs and priorities or to shifts caused by major political or humanitarian change? What was the quality of the response, particularly in relation to vulnerable and marginalized populations?

Summary UNFPA responded effectively to the main humanitarian change through contributing financially and technically to the national contingency plan and the Minimum Initial Service Package for refugees in Luapula Province.

UNFPA continued to concentrate efforts in provinces with poorest indicators for teen pregnancy, maternal mortality, child marriage and other SRHR needs, as noted earlier, thus focusing on vulnerable and marginalized populations.

The main humanitarian concern that arose during the 8CP was in relation to a growing number of refugees from the Democratic Republic of Congo (DRC) entering Nchelenge District in Luapula Province from 2017. By mid-2019 these numbered close to 15,000, approximately equal numbers of men and women, including over 3,600 women of reproductive age (KI interviews, group discussions and site visit). UNFPA contributed to the development of national contingency plan and delivering of the Minimum Initial Service Package (see EQ 2). For the past year, the response of the UN and multiple international and national development partners, led by UNHCR, has been to support GRZ to integrate the resettlement of refugees into the host population and, with regards health care, to establish a health facility rather than have staff travel to the resettlement area from existing health facilities elsewhere in the district. The facility opened in mid-2019, but remains to be fully equipped and to have electricity beyond solar provision. UNFPA was highly responsive to the sexual and reproductive needs of women and adolescents and youth among both refugees and the host population, such as different FP methods, ANC and EmONC services. The quality and extent of inputs was greatly appreciated (KI interviews, FGIs).

4.2 Effectiveness

4.2.1 To what extent did the interventions supported by UNFPA in all programmatic areas contribute to the achievement of planned results (outputs and outcomes), and how far were the planned geographical areas and target populations successfully reached in terms of coverage and quality of programmes?

Summary Employing all five modes of engagement, the 8CP has been an extensive programme that has contributed to legal, policy and strategy development and provided financial and/or technical support to 13 implementing partners in government and non-government organisations to address its mandate at national and sub-national levels, and also within communities. The latter has contributed to demand creation (e.g. for antenatal care and facility delivery), and changing attitudes and harmful practices (notably child marriage). Adolescent spaces have been established as planned, although they remain fairly basic. Extensive training and deployment of community volunteers is apparent, including young peer educators, safe motherhood action group members, and community based distributors for an increased mix of family planning methods. The 8CP contributed effectively to planned results and reached almost all the intended populations in the selected provinces and districts. Output targets were nearly all achieved or exceeded across the thematic areas. Measurable contribution of outputs to outcomes is variable both within and between thematic areas, and attribution is often complex given multiple players in some areas and extensive joint programming, and also because of limitations in comparable data.

4.2.1 Sexual and Reproductive Health

Achievements for sexual and reproductive health

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Sexual and reproductive health (SRH) was to be addressed by two outputs as indicated in the table below, with seven areas of intervention to achieve the first output, and three to achieve the second. Annex 1, the terms of reference, provides the full results framework. In line with these interventions, UNFPA is an active member of a range of multi-sectoral technical working groups (TWGs), including for safe motherhood, family planning (co-chair), procurement and supply chain management, adolescent health, HIV and AIDS, human resources for health, and for monitoring and evaluation (KI interviews, document review). The CO also keeps abreast of developments in the TWG for health care financing, participating in specific events but not attending routine meetings (KI interview).

The table below shows achievements against baselines and targets by year up to the second quarter of 2019.

Table 7: Zambia CPD M&E Matrix Results for Sexual and Reproductive Health in 8CP, 2016 - mid 2019

Outcome 1: Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access							
Indicator	**CPD Baseline**	**CPD Target**	**Achieved**				**Progress against targets**
			2016	**2017**	**2018**	**Mid 2019**	
Contraceptive prevalence rate for modern methods (%)	45	**58**			**47.5**		**47.5** **Not on track**
Unmet need for family planning (%)	21	**14**			**19.7**		**19.7** **Not on track**
% of births attended by skilled health personnel	64	**75**			**80.4**		**80.4** **Exceeded**
% of women and men with more than two partners in last 12 months reporting condom use	29.7 f 27.4 m	**50 f+m**			**38.2 f** **26.5 m**		**38.2 f 26.5 m** **Not on track**
% of young people aged 15-19 counselled and tested for HIV and received results	47 f 28 m	85 f 65 m			59.1 f 46.0 m		**59.1 f 46.0 m** **Not on track**
Output 1: National, provincial and district institutions have increased capacity to deliver gender-sensitive SRH and HIV services							
# of national guidelines with quality of care protocols available for the provision and monitoring of integrated SRH and HIV services	9	**12**	2	1	2	2	**16** **exceeded**
# of health facilities providing quality emergency obstetric care services in supported provinces	250	**400**	37	28	203	-	**518** **exceeded**
% of health-care providers with capacity to deliver quality, gender-sensitive SRH and HIV services in supported provinces	58%	**90%**	60%	64%	80%	91%	**91%** **exceeded**
# of fistula repair surgeries conducted in supported provinces	1786	**3,800**	208	310	220	51	**2,575** **on track**
Output 2: National, provincial and district institutions have the capacity to increase demand for and improve supply of life-saving reproductive health commodities and medicine, including modern contraceptives							
% of public health facilities with at least 7 life-saving reproductive health medicines and commodities in supported provinces*	66%	**80%**	75%	55%	90%	-	**90%** **exceeded**
# of male and female condoms procured and distributed per year (in millions, male, female)	34 m 1 f	**61.4 m** **1.6 f**	33.9m 1.1 f	46.1m 0.96 f	53 m	39 m	**172 m** **exceeded** **2.06 f** **exceeded**
# of health-care providers with capacity to deliver a method mix of family planning services in supported provinces	500	**1000**	185	272	1,029	255	**2,241** **exceeded**
# of additional users of modern contraceptives per year in supported provinces (in thousands/k)	238k	**900k**	316k	395 k	478 k	-	**478k** **not on track**

* All 10 provinces were supported

As indicated in the table, all targets for both outputs have already been exceeded with the exception of fistula repair, which is on track, and additional users of modern contraception, discussed below. With regards contribution to the outcomes, the results appear mixed. The contribution to outcome results by UNFPA is problematic to measure, particularly for provincial and district as opposed to national programming, as the outcome indicators are national (ZDHS 2013/14 as the baseline, and ZDHS 2018 as the measure of progress). Provincial data are available but these do not distinguish between districts let alone facilities supported by UNFPA and those that are not, and baselines and targets are lacking to compare UNFPA-supported and non-supported facilities. The intended geographical areas were reached, with programme achievements and challenges within each

intervention discussed below, and joint programmes under delivering as one (DaO) that cut across the specific intervention areas, addressed in EQ5.

In terms of the outcomes of increasing the modern contraceptive prevalence rate (CPR) and reducing unmet need for family planning (FP), progress is limited and off target. The CPR has only improved by about 2.5 per cent compared with a target of 13 per cent improvement over the CP to 2020 (the original end date), and the unmet need for FP has only reduced by 1.3 per cent, despite the efforts of GRZ, UNFPA and other partners. The most encouraging result is that the percentage of births attended by skilled personnel (essentially births in facilities assisted by trained doctors, clinical officers, nurses or midwives) has already exceeded the target. Reported condom use at last sex by men and women with two or more partners in the previous 12 months has increased for women but declined for men, despite the reported procurement and national distribution of male and female condoms having greatly exceeded targets. Regarding the proportion of adolescents aged 15-19 who have learned their HIV status, there has been a significant increase among males (18 per cent), and a smaller but significant increase among females (12.1 per cent) from a higher baseline. Despite this progress, fewer than half of males in the given age range have sought HIV testing, compared with nearly 60 per cent of females.

Throughout the CP implementation period, UNFPA has achieved a high level of delivery against annual planning (annual work plans, AWPs, and country office annual reports, COARs). Challenges are also noted. It would appear that UNFPA has underestimated the potential achievement of outputs, and new targets should be set for the extended CP period into 2021, with more challenging targets for the next CP. Whether this should include wider district coverage or reaching more sites and populations within the existing focal districts should be carefully considered based on a wider data base of where people are most vulnerable and considerations of feasibility, cost effectiveness and the potential for collaboration with other partners. UNFPA may want to consider whether to maintain and strengthen delivery in all the current provinces and districts and/or take on others with poor SRHR indicators.

With regards the theory of change behind the results chain, the current approach has demonstrated that the interventions and outputs around maternal health have been appropriate and contributed to outcome results, thus contributing to the transformative target of ending maternal deaths and the ICPD agenda, as discussed below. With regards FP uptake, the original indicator was new users, which was amended to additional users as a clearer measure of the overall extent of contraceptive use (CO interview and document review). The CP is not on track regarding the target for additional users in the supported districts (although, as noted below, UNFPA also provided extensive support to the national reproductive health commodity programme, including around 50 per cent RH commodity procurement). The output does not appear to have contributed significantly to reducing the outcome measure of unmet need for FP, let alone the associated transformative target of ending unmet contraceptive need by 2030. The focus of UNFPA specifically on condoms and also on all modern methods of family planning, and on procurement, supply chain management, health staff capacity building, and demand creation remain essential and appropriate, but the gaps and barriers that have limited their effectiveness need to be addressed further by UNFPA and other partners to achieve the intended outcome. Regarding gender and the transformative goal of ending gender based violence, the CP mainstreams gender within its programmes in several ways such as sensitisation of chiefs and health providers, including a focus on GBV, and ensuring data are gender disaggregated. Some change in gender values and attitudes has been documented in previous years,[90] but continued engagement of UNFPA remains important. Multiple partners are involved with GRZ in this area, and attribution to UNFPA will remain particularly problematic. For the SRH thematic area, the CP has clearly utilised all five modes of engagement in line with the theory of change. Regarding partnership and coordination, some joint programmes that cut across the different interventions below are addressed under EQ5.

Health provider capacity for emergency obstetric and newborn care

UNFPA supported the development of the emergency obstetric and neonatal care (EmONC) report, which influenced strategic EmONC interventions articulated in the National Health Strategic Plan 2017-2021. UNFPA also supported capacity development of health-care providers on effective planning, delivery and monitoring of high-quality (EmONC) services, including post-abortion care, and strengthened maternal death surveillance and response in line with international standards and guidelines (KI interviews and document review, see 4.2.4). UNFPA supported the institutionalisation of the Maternal Death Surveillance and Response (MDSR) system in 2016, and this appears to function well (KI interviews, review of documentation), enabling tracking of the benefits of early antenatal care and follow up, and of facility based deliveries. In 2017 the MDSR was modified to include perinatal deaths, reporting tools were revised, and UNFPA supported extensive

[90] Ministry of Gender (2017) 2016 Zambia National Gender Knowledge, Attitudes and Practices Survey Report

multi-sectoral provincial and district level meetings on the underlying causes of maternal deaths. Weekly facility reporting to the office of the MoH is reported (KI interviews) to have ensured that documentation is taken seriously.

Capacity development was achieved through supporting nurses and midwives in the selected provinces[91] to attend midwifery school, supporting the schools themselves (see next section), and providing sensitization and training on gender sensitive, integrated SRH, HIV and GBV. The number of health providers trained (including nurses, midwives, doctors and clinical officers) in the focal districts exceeded the target by mid-2019 (at 91 per cent, or over 900 of 1000 staff). In 2016 UNFPA also contributed to infrastructure development, and to medical equipment and other supplies to 39 facilities in the selected districts, although upkeep of the facilities and furnishings remains the responsibility of government and was observed to be inadequate. Field visits found that staff expressed motivation to provide integrated, gender sensitive services, although it was not possible to observe staff-client interactions. Records at the facilities were gender and age disaggregated, and with detailed records of antenatal clinic attendance and of maternal deaths.

Midwifery quality, production, deployment and retention

In the 7CP UNFPA supported the establishment of the Midwifery Association of Zambia, and in the 8CP has continued to support the Association technically and financially, together with the General Nursing Council, to hold government accountable for midwifery standards and regulations, and to advocate for increased midwifery posts. UNFPA provided technical and financial support for the development and finalisation of the Nurses and Midwives Strategic Plan 2017, including midwifery protocols. Also, UNFPA supported the Association to ensure that midwifery is well addressed in the Human Resources for Health Strategy 2018.

During the 8CP, UNFPA has provided extensive support to strengthen the quality standards of midwifery in the country, the training of nurses and midwives, the expansion of posts and the retention of midwives (CO interview) and, as above, mechanisms to promote government accountability. Overall, the contribution of UNFPA to strengthening midwifery has been substantial, and highly likely to have contributed to declining maternal mortality in areas where it had been highest.

In the 8CP UNFPA has provided scholarships for one-year midwifery training for nurses to upgrade to midwifery. The CO has also directly supported midwifery schools with library materials, computers, models and other requirements for the skills labs and general training. Field work found that the schools have benefited considerably (KI interviews and site visits). UNFPA has also increased the carrying capacity of midwifery schools to increase the number of trained midwives.

Retention of trained midwives has been challenging as their remuneration package is not high and there is little prospect for career development. Through the Midwifery Association UNFPA advocates for a better package. Further, UNFPA is supporting the Ministry of Health, the Nurses Council and the Midwifery Association to develop curricula at bachelors and masters level at the University of Zambia to create the potential for career development within midwifery.

Fistula

The aim of the 8CP (RF) was to institutionalise routine fistula case identification, treatment and linkages to social reintegration programmes, in line with international standards. UNFPA has undertaken advocacy, capacity development, knowledge generation and service provision in relation to fistula. Since 2017 the international Fistula Foundation has also been operating nationally in Zambia, with its country office in Mansa, Luapula, and it is now contributing significantly to fistula identification and repair throughout the country. The Foundation accompanies women to treatment facilities, paying for transport and other costs, and operates a telephone hotline. A road map to end fistula is under development by GRZ, UNFPA and the Fistula Foundation. Although currently (KI interviews) linkages between UNFPA and the Foundation do not appear strong, it is to be hoped that through the road map effective collaboration in support of the Ministry of Health will be clarified, maximising the comparative advantage of each partner. The ideal will be to have a highly trained fistula surgeon in each province to bring the services nearer to clients.

Of the target of 3,800 fistula repairs by 2020, 2,575 had been undertaken with UNFPA support by mid-2019 building on the baseline of 1,786 undertaken in the previous CP. The numbers had dropped off in the first half of 2019 compared with earlier years, however, further fistula camps are still planned. UNFPA has contributed by training obstetricians in fistula repair, supporting fistula repair camps, and raising community awareness about fistula through community volunteers such as

[91] Luapula, North-Western, Central and Western

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SMAGs. Typically, women who have suffered from fistula have been shunned, with poor quality of life, little employment, low self-esteem and little awareness that anything could be done.[92] While the camps provide an important service, they are not sustainable. A more sustainable approach has been training obstetricians at provincial level to undertake fistula repair and supporting a ward at Mansa General Hospital that has intakes every six weeks of maximum 16 fistula patients who stay for two weeks and have access to counselling and support, including for SRH, as well as medical fistula repair. Being in a group for two weeks also promotes bonding and confidence building and was greatly appreciated by the group of 11 women present on the field visit (FGI with beneficiaries and staff KI). All had been living with fistula for several years. Within this group, and corroborated by KI interview, fistula is associated with obstructed labour that can occur at any age. Adolescent child bearing poses increased risks, however, particularly among very young mothers. In the majority of cases of obstructed labour leading to fistula the baby does not survive.

Although the UNFPA focus was initially on identification and treatment, the CO has also contributed to fistula prevention through increased attendance for antenatal care and for facility based delivery (KI interviews, focus group discussions with SMAGs). One SMAG member commented with vigour, '***I don't want to see any new fistulas here, no, not one. We must prevent them all.***'

SRH and HIV linkages and response to gender based violence

The RF intervention of rolling out SRH and HIV linkages service models at health facilities, alongside the health sector response for gender based violence, was addressed from 2011 to 2017 through the ten-country SRHR/HIV Linkages Project, eight countries in Southern Africa and two in East Africa.[93] In 2016 three additional countries joined the project. The project was jointly led by UNFPA and UNAIDS with EU, Swedish and Norwegian funding and the involvement of the Planned Parenthood Association of Zambia (PPAZ). The logic and importance of linking service provision for SRHR and HIV are clear, with the aim of improving health outcomes through integrated and streamlined service provision, reducing stigma and discrimination, reducing duplication of effort and increasing cost effectiveness and efficiency of service delivery.[94]

In Zambia the Linkages Project is described as catalytic in reinforcing primary health care by the MoH, promoting government ownership of and commitment to providing integrated services, and raising the awareness and commitment to integrated services among international and national cooperation partners and donors.[95] Multiple lessons learned and recommendations stem from the experience of the Linkages Project relating to coordination, partnerships, policies, strategies and guidelines, monitoring and evaluation, improving service delivery and building health worker capacity. Documenting and sharing good practices from the project experience should contribute to scale up of integrated services in other health facilities. Two specific good practices that were noted were the need fully to use participatory approaches in the development of communication materials, and to find innovative ways of documenting and sharing information so that it is appropriate for and accessible to different audiences.

Building on the Linkages Project, guidelines on integration[96] were developed in 2015 by the MoH, with UNFPA technical and financial support, that inform integrated service programming in the 8CP across broad SRHR areas.[97]. During the 8CP, (KI interviews, document review, site observation) UNFPA has built human capacity and resources for integrated facilities in the selected districts within North-Western Province, Luapula and Western Province, with staff trained for SRHR and HIV, adolescent friendly services, and counselling for survivors of GBV (predominantly intimate partner violence, IPV). UNFPA has also strengthened capacity among health providers for a gender focus and to address gender based violence. Adolescent SRH services include setting aside specific sessions for adolescents and establishing adolescent corners. Health provider awareness and support for people with disabilities in accessing SRH services has also been raised, although this needs further development.

The model integrated sites provide antenatal care and facility based delivery, basic EmONC services, comprehensive family planning, HIV counselling and testing, and antiretrovirals for PrEP and treatment. However, the quality and upkeep of facilities, the responsibility of government, is poor (site observation) and not conducive to the optimal provision of integrated service

[92] Findings of Zambia's Fistula Tracking Study 2014
[93] UNFPA and UNAIDS Project on SRHR and HIV Linkages in Ten Countries in Southern Africa. Zambia Close Out Report (no date).
[94] Ibid.
[95] Ibid.
[96] Ministry of Health (2015) National Guidelines for SRH, HIV and GBV Services Integration
[97] These include safe motherhood, newborn and child health including emergency care, family planning, adolescent SRHR, prevention and treatment of fistula, cervical cancer screening and HPV vaccination for girls, comprehensive abortion care services, HIV prevention, treatment and care, and addressing GBV

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provision. At one site post-natal mothers were being discharged only six hours after delivery if no complications were apparent (KI group interview), on the grounds that there were not enough beds to keep them longer. In one hospital, the condition of the antenatal ward was so poor that the women had to be moved elsewhere (site observation and KI interviews). Privacy is also sometimes compromised by the lack of space, not just regarding beds but also with regards HIV testing and counselling. The extent to which clients need to queue separately to address different SRH needs appears to vary between sites (KI interviews and observation).

In the previous CP and the first two years of the 8CP, UNFPA together with UN agencies (notably WHO, UNICEF, UNDP, IOM, ILO, UNHCR) and several NGOs participated in the pilot GRZ/UN Joint Programme on Gender Based Violence, 2012-2017, in line with delivering as one (DaO). An independent evaluation[98] found as good practice setting up One Stop Centres, Fast Track Courts, Men and Community Networks, and Own Savings for Assets and Wealth (OSAWE) groups, and recommended scale up. However sustainability of the programme is a challenge, and the recommendation was to scale up only to a limited number of districts that could implement the full menu of programme interventions. One recommendation was also to include a focus on people with disabilities who were not addressed in the initial programme. Another recommendation was to improve coordination between stakeholders in the referral chain. Phase II is about to commence with UNFPA, UNDP, UNICEF, ILO and IOM support.

Building on the Linkages Project and the joint GBV programme, a three-year joint regional programme "2gether for SRH commenced in 2018. Under this programme, UNFPA engaged the Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS) to further develop comprehensive integrated SRHR/HIV/SGBV services in conjunction with the Ministry of Health and other stakeholders. The support from UNFPA included the development of guidelines on effective linkage, oversight and management, and GRZ is reported to have started mentoring service providers on using the guidelines to assure integrated services at all levels of care from health posts, rural and urban clinics, to district and provincial hospitals. The extent to which this is already operationalised was not assessed by the evaluation team. The intended programme beneficiaries are broad, including female and male adolescents and youth, people living with HIV, pregnant and breastfeeding women, and lesbian, gay, bisexual, transgender and intersex populations (document review, KI interview).

With regards human rights for survivors of GBV, most often intimate partner violence (IPV), health staff visited in the supported provinces have been sensitised and indicated positive attitudes to counselling and supporting clients (KI and group interviews). However, the link with the police, courts and seeking justice against the perpetrators appears weak, particularly in rural areas where there may be no nearby police stations or police officers, or formal court systems.[99]

Staff reported (KI individual and group interviews) that they would recommend that survivors go to the police and press charges but did not accompany survivors, even in cases of rape or child 'defilement'. Although they kept close records of incidents of violence (KI interviews and review of records), they kept no records of outcomes of referral. The unanimous finding (KI interviews with staff) was that survivors of violence, especially wives, rarely feel empowered to seek redress because they are economically dependent on their spouse, and because of traditional views that are still too accepting of domestic violence. They may seek help from the local chief or headman. Therefore supporting sensitization workshops provided by UNFPA for these custodians of culture is strategic. Even at the GBV dedicated One Stop Centre at Solwezi General Hospital, which has paralegal support, little was reported to be taking place beyond the direct support to survivors, and maintenance of a safe house that could accommodate fewer than 10 people with a time limit of three weeks' stay.

The programmes for integration of SRHR services are progressing well, but the aspect of justice for survivors of GBV and the inclusion of people with disabilities remain challenging and under-developed.

Contribution to the humanitarian response

In Nchelenge District, Luapula Province, UNFPA has contributed effectively to the national contingency plan and the design and delivery of the Minimum Initial Service Package, as planned in the RF, including assisting in drafting the planning document (KI interviews, document review) and contributing to the implementation of interventions supported by the joint UN Central Emergency Relief Fund. The contributions of UNFPA were highly valued by the GRZ and partners, with the CO reaching 99 per cent of its intended beneficiaries regarding integrated SRHR/HIV and GBV services. According to KI

[98] Independent Evaluation of the GRZ/UN Joint Programme on Gender Based Violence: Final Evaluation Report, 2017
[99] UNDP, not UNFPA, has the lead responsibility within the UN regarding adjudication around GBV in the UNJSPF and are mandated to work with the police.

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interviews, FGIs, and document review,[100] UNFPA by 2018 had: provided financial and technical support for emergency obstetric and neonatal care (EmONC) equipment and deployed five midwives; trained 30 Safe Motherhood Action Groups members (SMAGs), 22 personnel in GBV prevention and response, and 17 peer educators among young people to raise awareness and increase demand for antenatal services and for family planning. By mid-2019, according to KI interviews, reports indicated reduced home deliveries and an increase in FP uptake, particularly of injectables, although the team was unable to verify or quantify this finding. As noted in EQ1, UNFPA also supported the equipping of the health facility in the resettlement area.

Demand creation interventions addressing social norms and cultural practices around SRH

With regards promoting evidence-based and innovative demand-creation interventions to address negative gender and social norms and unequal power relations that impede equitable access to SRH and HIV services (RF), UNFPA has engaged with chiefs and headmen[101] and also religious leaders in the community through sensitization and training sessions in all UNFPA supported provinces. These custodians of culture and tradition have been sensitised on gender and GBV, on the harms to girls caused by child marriage, around the needs and rights of adolescent girls and boys to access SRH information and services, and regarding the SRHR of people with disabilities. The latter includes addressing stigma, myths and misconceptions and planning for social protection of people with disabilities in religious institutions and chiefdoms (KI interviews, document review). This approach is an important contribution to changing community perceptions of men and women around gender inequality, the empowerment of women to address unequal and harmful power dynamics, and GBV. Addressing patriarchal norms and values that disempower women and girls has long been a major focus for the CO that has continued into the 8CP (document review, KI interviews). Some change in attitudes and perceptions had already been achieved between 2012 and 2016 according to UNDP and DfID-supported surveys by the Ministry of Gender,[102] but GBV, particularly IPV, remains a major concern, as noted earlier, and severe gender inequalities remain. The integrated SRH, HIV and GBV programming includes aspects of demand creation also for integrated services including with respect to GBV.

Another important change in traditional practice and gender norms, being realised by SMAGs and CBDs, is the belief that women should be strong in enduring labour and that it shows weakness to seek professional support. Prolonged labour was reported as being widely seen as evidence of wrong doing by the husband, such as infidelity, (KI IP and CO interviews), although women are not empowered to confront this. Changing these beliefs is instrumental in reducing the first delay regarding access to obstetric services and in encouraging men to accompany their wives to facilities for delivery, which was strongly reinforced by midwives, and SMAGs (KI interviews). An unintended consequence, however, was that some facility staff reported in interviews 'chasing' women who arrive for antenatal services without their partner/husband, or giving priority to those who are accompanied. As it was not possible to assess the extent to which this may actually be occurring, this is considered a tentative finding requiring further investigation.

Training of peer educators in the supported districts and provinces aims at increasing demand among young people to take up services, and the training of CBDs and SMAGs in the communities has contributed to raising awareness and uptake of modern contraception and antenatal care and facility-based delivery respectively. However, as noted earlier, the contraceptive prevalence rate needs greatly to improve and demand creation needs to be strengthened. Section 4.2.2 elaborates further on demand creation activities addressing young people.

Multi-sectoral coordination mechanisms at national and provincial levels for SRHR

Advancing the SRHR agenda through supporting multi-sectoral coordination mechanisms at national and provincial levels (RF) has been undertaken in several ways and was assessed as highly effective and valued (KI interviews, extensive document review). The 7NDP indicates the revised GRZ coordination mechanisms at national and sub-national levels aiming to achieve stronger synergies and efficiencies.[103] As well as contributing financial and technical support to the development of the 7NDP, (KI interviews and document review) UNFPA has engaged actively with the coordination mechanisms through the National Development Coordination Committee and the Cluster Advisory Groups, and in the monthly review meetings and quarterly joint monitoring visits coordinated by MNDP. At provincial level, through its sub-offices, UNFPA is active in the Provincial Development Coordination Committees. The CO is also active in the RMNCAH&N technical working groups

[100] Resident/Humanitarian Coordinator's Report on the Use of CERF Funds, Zambia Rapid Response Displacement 2018
[101] Nearly all chiefs and headpersons are male according to CO feedback.
[102] Ministry of Gender (2017) 2016 Zambia National Gender Knowledge, Attitudes and Practices Survey Report
[103] 7NDP 2017-2021

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(TWGs) for reproductive, maternal and adolescent health, as well as for HIV. UNFPA co-chairs the family planning TWG and is an active member of the Adolescent Health TWG, with the lead on advocacy and policy dialogue. The UNFPA sub-offices help convene and support the provincial meetings, but do not participate in District Development Coordination Committees (CO feedback and document review). The Ministry of Gender leads the Gender Cooperating Partners' Group, a gender advisory group with multiple UN inputs, to which UNFPA provides technical support in the areas of its mandate. UNFPA also engages with the Human Rights Commission on SRHR related issues, which has led to the adoption of key SRHR recommendations by GRZ during the UN Universal Periodic Review of Zambia. At UNCT and technical levels UNFPA is actively involved in UN coordination activities and has contributed extensively to the DaO structures (results groups and theme groups) and to their linkages with the multi-sectoral cluster meetings and TWGs. In 2019 UNFPA was also actively engaged with the Resident Coordinator and the UN partners in restructuring the DaO mechanisms to achieve better alignment, efficiency and effectiveness internally and with GRZ mechanisms. EQ 5 provides further information on the UNCT and DaO.

UNFPA has also engaged actively in H4+ coordination and H6, and in several jointly planned, coordinated and implemented programmes for SRHR during the 8CP, with UN, government and other partners (see EQ5). Examples are the RMNCAH&N programme 2018-2021 jointly with UNICEF and with DfID funding to support MoH health systems strengthening in 28 districts in two provinces. The programme assisted establishment of the RMNCAH&N Steering Committee within the Inter-agency Coordination Committee chaired by the MoH Permanent Secretary. At the time of the CPE the RMNCAH&N programme was being jointly redesigned for a further phase. Another example is 2gether 4SRH, jointly with UNICEF, UNAIDS and WHO with Swedish funding to strengthen MoH delivery of integrated SRH, HIV and GBV. A third is coordinating with ILO on the disability project funded by the UNPRPD Disability Fund to promote the inclusion of disability in integrated SRH, HIV and GBV (see 4.2.3), and there is also joint programming to end child marriage. GRID3 is a joint programme with Flowminder and CIESEN[104] to generate and promote the use of high resolution geo-referenced data (see 4.2.4 on population dynamics).

Advocate for domestic funding for reproductive health commodities and medicines while meeting procurement shortfalls

With Zambia re-classified as an LMIC, UNFPA has heightened its advocacy for tracking FP indicators and for increased domestic financing for FP commodities. This is in line with the global UNFPA supplies programme that differentiates funding to countries according to their economic status and population growth. UNFPA is in process of supporting the Ministry of Health to develop a financial sustainability plan for FP by the end of 2019, to transition towards increased domestic funding. Currently UNFPA procures nearly 50 per cent of the annual national FP commodity needs for Zambia (KI IP and CO interviews), and has sustained substantial procurement throughout the CP (COARs). Many partners cooperate within Zambia on FP, but only UNFPA (with DfID funding) and USAID contribute directly to commodity procurement. Despite the aim of increasing domestic funding, it will be challenging for GRZ to address the commodity needs in the constrained fiscal space for development, including for the procurement of commodities.

To strengthen FP service provisions for hard to reach populations, expand the methods mix, and to achieve task shifting into the community, UNFPA has supported MoH to develop a national road map to scale up DMPA[105] through training CBDs. They are already being trained in the supported districts, with the additional benefit of easing pressure on the health facilities (KI interviews and FGIs) the more they provide a comprehensive method mix in the community.

Through the Procurement Services Branch, UNFPA has also strengthened the capacity of UNFPA partners, notably the Zambia Medicines Regulatory Authority and Zambia Bureau of Standards, regarding quality assurance of male condoms.

Capacity development for evidence-based supply chain management and for last mile delivery

The RF includes developing capacity for evidence-based forecasting, quantification, logistics and supply chain management systems, including last mile distribution from national to health facility levels. UNFPA has provided technical and financial support for forecasting and quantification through the development and testing of an estimates tool that is being adopted by the MoH with ongoing training for NAC and the MoH. Quantification and stock availability for reproductive health

[104] Centre for International Earth Science Information Network
[105] MoH (2018) National Road Map to Support Scale-up of Intramuscular and Subcutaneous Depot Medroxyprogesterone Acetate (DMPA) by Community Based Distributors in Zambia (2018-2021)

commodities is reported to be good at central level within Medical Stores Limited, with UNFPA support (KI interviews) and oversight. Efficiencies for storage and distribution at that level would reportedly be improved, however (KI interview) with adjustment of the size and scale of packaging and storage pallets, and the stakeholder has communicated this to UNFPA to consider. Distribution is to MSL hubs in seven provinces or to GRZ district offices where there is no hub, and storage facilities at both hubs and the district offices is reported (KI interviews) to be good, although this was not verified during the field work. UNFPA and the Churches Health Association of Zambia (CHAZ) support last mile distribution from the hubs with contribution also by Chemonics (US). Although improvements were noted through the LMIS,[106] forecasting, quantification and last mile distribution need strengthening further, as most facilities visited during the CPE indicated occasional stock outs of particular FP methods. Male condoms need particular priority, being preventative of HIV, other STIs and pregnancy. In Solwezi during the CPE UNFPA contributed to an emergency effort to ensure stocks of male condoms for an upcoming traditional festivity where large numbers of people congregate and casual sex is common.

UNFPA collaborated with the MoH to conduct the Reproductive Health Commodity Supply (RHCS) Survey in 2016, 2017 and 2018, a national survey to assess availability and stock outs of essential maternal and reproductive health medicines and modern contraceptives. Primary service delivery points had 95 per cent availability of three or more contraceptive methods, but with stock outs of certain contraceptives. Field visits also found stock outs of the increasingly popular injectables (Depo Provera) and certain implants, but with other options available.

UNFPA has also provided financing and technical support for the development of the National Comprehensive Condom Programming Strategy 2018-2021, that was nearing completion at the time of the CPE. This states the importance of taking a total market approach to condom programming, with emphasis on: 1) strengthening government stewardship, 2) implementing strategies for condom market development and management at national and district level, 3) developing and operationalising knowledge management for condom market sustainability, 4) conducting mid-term evaluation and review, 5) ensuring quarterly quality assurance mechanisms, 6) implementing operational market research, 7) targeting mass media based condom promotion at all levels, and 8) conducting final evaluation. UNFPA should be a key player in assisting coordination, implementation and monitoring and evaluation of the strategy.

Gender sensitive family planning for services for marginalized and key populations

The 8CP (RF) aimed to innovate and document success factors for gender sensitive family planning, including male and female condoms, within marginalized and key vulnerable populations. Interventions included advocacy for an enabling environment, contributing to an expanded methods mix, and training and task shifting to CBDs to reach more marginalized populations with a wide range of contraceptive choices. Regarding HIV prevention, UNAIDS identifies 12 populations left behind. Within the UNFPA mandate for SRH and HIV integration these include: young men and women; antenatal women; people with disabilities; sex workers and their clients; men who have sex with men (MSM) and transgender populations; and migrants and mobile populations. UNFPA support for the SRHR needs of people with disabilities is addressed in 4.2.3.

As noted in EQ1, the needs and rights of key populations of sex workers, MSM and lesbian, gay, bisexual, transgender and intersex (LGBTI) populations are insufficiently addressed. They face severe stigma, discrimination and criminalisation, with many challenges to addressing their SRH needs and rights, especially for HIV prevention and treatment. Addressing their needs is one of the five pillars for HIV prevention in the global UNAIDS Road Map for HIV Prevention, and UNFPA, co-sponsor with UNAIDS to reduce sexual HIV transmission, argued strongly for their inclusion in the domesticated road map for Zambia (KI interviews, document review). The September 2017 review of progress for the key populations[107] found almost no progress, however. It recommended advocacy with government to review the hostile legal and policy environment, increasing the knowledge base, which is insufficient, establishing a technical working group or other mechanism to support design and implementation of tailored programming, sensitizing civic and traditional leaders to destigmatise key populations, providing a safe platform to key populations to access SRH/HIV services, and training and sensitizing health staff to change negative attitudes.

Various UN partners and civil society organisations are engaged in addressing these concerns, including providing sensitization and awareness generation and what might be called 'subtle advocacy' (KI interviews). Interventions are underway with Global Fund and PEPFAR[108] and UBRAF financial support. During the 8CP UNFPA (KI IP and CO

[106] Logistical Management Information System
[107] National HIV/AIDS/STI/TB Council (2017) Zambia National HIV Prevention Coalition road map
[108] The Global Fund for HIV, Tuberculosis, Malaria and other Infectious Diseases; the President's Emergency Plan for AIDS Relief

interviews) has not played a substantial role regarding these populations, given the many development and NGO partners already engaged. However, as part of integrated SRH/HIV/GBV programming it would appear appropriate for UNFPA to strengthen its contributions to sensitization and awareness generation, to consider support to the weak networks of these populations and to engage in sensitive advocacy for legal and policy change to generate an enabling environment.

4.2.2 Adolescents and Youth

The adolescents and youth (AY) thematic area has been addressed by two outputs as in the table below, with three interventions to address the first, and three the second. 4.2.1 indicates the technical working groups in which UNFPA participates for SRH, including for adolescents and youth, with the addition of work on comprehensive sexuality education (CSE). The table provides the achievements against output targets by year for AY, with the outcome indicators reflecting the baseline data from the ZDHS 2013/14. All five modes of engagement have been employed, including significant upstream advocacy and contributions to policy development.

Table 8: Zambia CPD M&E Matrix Results for Adolescents and Youth in 8CP, 2016 - mid 2019

Outcome 1: Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health							
Indicator	**CPD Baseline**	**CPD Target**	**Achieved**				**Progress against targets**
			2016	**2017**	**2018**	**Mid 2019**	
# of provinces implementing rights-based, comprehensive sexuality education programmes for in and out of school youth	0	**3**	**7**	**7**	**7**	**7**	**7 exceeded**
# of provinces denouncing child marriage practices	4	**8**	**-**	10	-	10	**10 exceeded**
Output 1: Increased capacities of national, provincial and district institutions to design, implement and monitor comprehensive sexuality education programmes that promote human rights and gender equality							
# of national laws and policies that promote access to gender-sensitive and rights-based adolescent sexual reproductive health	0	**2**		1		1	**2 achieved**
# of provinces with capacity to deliver quality youth-friendly health services that are aligned with international standards	5	**10**	7	7	7	7	**7 on track/ achieved**
Output 2: Increased capacity of national, provincial and district institutions to design and implement comprehensive programmes for marginalized adolescent girls, including safe spaces, for those at risk of child marriage.							
# of community-based organisations with capacity to design and implement safe spaces programmes for marginalized adolescents	4	**20**	4	10	14	38	**70 exceeded**
# of community leaders leading community-based social and economic assets-building programmes to reach girls at the risk of child marriage (traditional and religious leaders)	20	**50**	1,066	490	235	53	**1,864 greatly exceeded**

Achievements for adolescents and youth

Almost all targets have been exceeded, the final one, regarding community leaders, greatly exceeded as the programming was significantly stepped up and includes chiefs, headmen, religious leaders, wives of traditional leaders and others, and was particularly scaled up during the 8CP in the Ending Child Marriage Programme (KI interviews, document review). Regarding national laws and policies, the 8CP contributed, for instance, to the National School Health Policy 2017 and the Adolescent Health Strategy 2017-2021, and to other strategies in the previous CP cycle (e.g. The National Youth Policy 2015 and the National Strategy on Ending Child Marriages 2016-2021).[109] The development of adolescent friendly SRH (ASRH) services has been supported in all 10 provinces to an extent, given national advocacy, technical and financial support from UNFPA (including the development of policy briefs related to AY SRH for parliamentarians and policy makers).[110] In the seven selected provinces for UNFPA engagement, direct health care provider training has included training of trainers to cascade the sensitization and training to the other provinces and districts. The outcome results have also been exceeded, with the

[109] Ministry of Gender (2016), National Strategy on Ending Child Marriages 2016-2021
[110] Three policy briefs on child marriage, CSE and ASRH, and teen pregnancy respectively, as well as two on broader SRH, and on HIV and GBV

assumption that the programming by UNFPA and its partners directly contributed to these positive results. Nonetheless, the second outcome measure, provinces denouncing child marriage, is merely indicative of policy direction rather than practice.

The theory of change underlying the results chain and the selection of indicators appear not to be fully aligned, although they are clearly related to the overarching intended outcomes. Output one focuses on capacity development for CSE programmes, yet the indicators relate to laws and policies favouring adolescent access to SRHR and to provinces delivering quality ASRH services. One of the three interventions under the CSE output relates directly to the output, (review of in-school CSE curricula), but the other two appear only tangentially related. These are: scaling up out-of-school programmes to provide equitable access to integrated SRH information and services; and supporting policy coherence and multi-sectoral coordination mechanisms for youth health and development programmes. Thus activities documented in COARs and with stakeholders, while designed to contribute to the overall goal of improved indicators for adolescent sexual and reproductive health, do not fit neatly into the specified output of CSE programming but rather to policy, coordination and ASRH service delivery. The indicators for Output Two, on comprehensive programmes for marginalized girls, including safe spaces and addressing child marriage, are well aligned, as are all three interventions under this output (see below). Nonetheless, documenting them in the CPE under the specific interventions is somewhat confusing, as activities overlap (document review, COARs, CO feedback) and the same few programmes provide support within several intervention areas.

A key challenge in improving integrated ASRH services is the constrained fiscal space from government to sustain and also monitor quality SRH services overall (as noted in 4.2.2), with inadequate funding for health despite the commitment of the Ministry of Health to strengthen primary health care, including for adolescents and youth and greater attention to youth in the 7NPD. Also, within UNFPA, the funding envelope has been low (see Chapter 3), with almost no core resources, despite the adoption of AY as its own thematic area in the 8CP.[111] Also there is only one full-time programme officer for AY (who also addresses the UNFPA HIV response) and a UNV for youth involvement, with 50 per cent time allocation by a maternal and adolescent health analyst who addresses child marriage jointly with the gender specialist. In the office, it might be useful to ensure stronger integration of AY, gender and full SRHR programming while maintaining AY as a thematic area. As well as improving adolescent and gender friendly services themselves, achieving comprehensive SRHR knowledge, safer sexual behaviours particularly among marginalized and impoverished adolescent girls, and an enabling environment for service uptake by young people are major challenges against which some progress has been made in the 8CP (as below).

Capacity development for out-of-school programmes

The first output, regarding comprehensive sexuality education (CSE), has been addressed by several modes of engagement in different provinces and programmes. The first RF intervention is targeted capacity development of provincial and district level staff to strengthen innovative out-of-school programmes that scale up equitable access to high-quality, youth-friendly and gender-sensitive SRH information and services, including for HIV prevention. The 8CP provided financial and technical support for extensive sensitization efforts on SRHR, HIV and GBV integration at national and sub-national levels (KI interviews, document review) including for adolescents (see 4.2.2). The evaluators found positive attitudes at both levels towards adolescent access to integrated SRH, support for adolescent corners in the health facilities, and for peer educators in the community although UNFPA contributions to funding and to monitoring were limited (as addressed in Chapter 3).

A key programme for this intervention is Safeguard Young People (SYP). SYP, implemented by the Young Christian Women's Association (YWCA) in three districts, Samfya District in Luapula, Mufumbwe District in North-Western, and Kaoma District in Western Province, in conjunction with the Ministry of Health and the Ministry of Youth, Sports and Child Development, aims to contribute to strengthening the SRH status of young people 10-24 through high level advocacy regarding the age of consent to access SRH services, development of comprehensive guidelines and revision of adolescent health standards, as well as advocating for disaggregation of data on age and sex in the HMIS (KI interviews, document review). SYP has completed two phases, starting in the previous CP, with the second phase ending in 2019 and the third phase to run from 2020-2022, and has had an average annual budget of US$350,000 mobilised through UNFPA, and US$ 2 million mobilised through UNESCO. The first phase concentrated most on the upstream activities, with more focus in the second and third phases on capacity building, sensitisation and service provision through the peer educators, an appropriate progression.

The overall intervention for out-of-school young people included extensive recruitment and training of peer educators to reach young people in the community, together with establishing adolescent corners, deemed safe spaces. Peer educators were

[111] The declining regular resources envelope has primarily covered programme coordination assistance and population dynamics.

trained and deployed within the joint RMNCAH&N programmes (see SRH above, and EQ5),[112] which also built capacity of health care providers in ASRH, as did the 2gether 4SRH programme. The Millennium Development Goals Initiative (MDGi) also trained and supported peer educators in Copperbelt and Lusaka provinces. The SYP programme trained safe space mentors who integrated out-of-school CSE with the safe space curriculum on ending child marriages (KI interviews, document review). The 2gether for SRH three-year programme has trained a 'critical mass' of peer educators in four districts each in Western and Central provinces on the out-of-school CSE curriculum (KI interviews, document review). The curriculum was developed with UNFPA support in the previous CP. The programme is also engaged with the MoH M&E department to ensure that HMIS data, already disaggregated by sex, are also fully disaggregated by age, and will also pilot a tool in the two provinces on documenting integrated SRH, HIV and GBV data.

During field work in the selected health facilities in the UNFPA supported provinces (KI interviews, document review, FGIs) a number of challenges were identified. Attrition among peer educators was reported by facility staff to be a challenge in some centres, and site observation showed that the adolescent corners are essentially small rooms with few facilities, although FGIs with peer educators and staff comments indicated high enthusiasm and good basic knowledge. Peer educators also distribute (mainly male) condoms, thus increasing community access to them. Challenges expressed unanimously by peer educators included the lack of educational/social behaviour communication materials, lack of sufficient space for discussions and meetings with larger groups, non-remuneration for all their activities, and the lack of basic incentives such as t-shirts, bags, bicycles to facilitate reaching more marginalized adolescents, and refresher training. They also wanted recreational facilities to encourage young people to come to the health facilities. Facility staff reported that young people tend to be relatively mobile and may move out of the area, increasing rates of attrition. In the sites visited, peer educators included both girls and boys in broadly equal numbers. UNFPA needs to assess the comparative advantages of continued recruitment and training of peer educators as a strategy, in terms of increased SRHR knowledge and uptake of young men and women of integrated SRHR, HIV and GBV services, and explore modalities for retention of peer educators.

The CO, through SYP, supported the ministries of education and health in further capacity development of teachers and health providers within the supported provinces, reaching substantial numbers of in and out-of-school young people (among the latter, the COAR reports that in 2018, 48,945 young people were reached out of an annual target of 30,000). Thus roll out was extensive, and primary and secondary beneficiary FGIs in the health facilities and schools visited indicated that they had gained knowledge and increased access to integrated SRHR services. Positive attitudes were expressed by staff towards increased adolescent SRH within the school and facility settings, and in interviews with Board of Education members.

In addition to training duty bearers, UNFPA engaged SAfAIDS[113] to support out-of-school access to ASRH information through various means. This includes widespread and repeated condomize campaigns that are estimated to have reached millions of young people (AWPs, COARs, KI interviews, FGIs) to raise awareness around the risks inherent in unprotected sex, and to motivate safer behaviours, including around alcohol and substance use that contribute to riskier sex.[114] In Western Province a weekly interactive radio series called 'Tune Me' is estimated to have reached approximately 35,000 young people in 2018 (KI interview, document review), and a TuneMe online mobile site was set up to empower AY with SRHR information, reportedly reaching 600,000 young people nationwide. This initiative was implemented by SAfAIDS with CO technical and financial support in collaboration with three ministries,[115] demonstrating a multi-sectoral partnership. In 2019 the Tune Me platform is being expanded into all other provinces with Global Fund financial support. Awareness creation by the 2gether 4 SRHR project is also working towards generating wider community acceptance of the needs and rights of adolescents to SRH. Under 2gether 4 SRH a new booklet aimed at girls in secondary and tertiary education was nearing completion at the time of the CPE, as well as a series of posters and other materials for an upcoming campaign in the third quarter of 2019 (observation and KI interview). Thus a range of complementary and mutually reinforcing approaches have been developed over the course of the 8CP to reach out-of-school adolescents, building on efforts in the previous programme cycle. Nonetheless, reducing the number of teen pregnancies and reducing HIV acquisition remain serious challenges. The joint MDGi, addressed in EQ5, does appear to have had some impact on teen pregnancy in the two provinces of Copperbelt and Lusaka, and the lessons learned in that programme should be applied further and more widely in the next phase.

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[112] Extensive RMNCAH&N is also underway with Swedish and USAID support in other provinces and multiple districts, with UNFPA engagement only at national level.

[113] Southern Africa HIV and AIDS Information Dissemination Service

[114] National Comprehensive Condom Programming Strategy 2018-2021 (draft)

[115] Ministries of Health; Youth, Sports and Child Development, and of General Education

Review of CSE curricula

The second intervention for CSE was advocacy for and review of in-school CSE curricula to ensure incorporation and delivery of gender-sensitive sexual and reproductive health components through school grades 5 to 12 (RF). Changes in curricula were approved at policy level, and programming was supported in all provinces. Advocacy by UNFPA, UNESCO, UNICEF and others also led to the incorporation of CSE as an examinable subject at grade 12, an important development to stimulate schools to give due weight to completing the curriculum. Capacity development of examiners to set questions on comprehensive knowledge of SRH and HIV took place in 2017 (document review, KI interviews) with UNFPA and UNESCO support. These are important results that should lead to sustained benefits in the knowledge of in-school young people on SRH, sexuality, and gender relations.

With Sida funding, UNESCO successfully supported the Ministry of General Education with a five-year national project from October 2013 to March 2018 to roll out CSE within carrier subjects to strengthen access to high quality CSE.[116] However, despite increased knowledge, adolescent uptake of SRHR services remained too low. A second phase is beginning in 2019 (KI interviews, document review), Our Rights, Our lives, Our Future to improve SRHR, gender and educational outcomes for young people, addressing HIV, STIs, teen pregnancy, and GBV. To strengthen the evidence base for what works, UNFPA and UNICEF have engaged Population Council to model three approaches to link in-school adolescents with SRH services with the aim of increasing adolescent knowledge of SRHR/HIV and service uptake (CSE-ASRH linkages study).[117] This implementation science project includes an arm in which health providers come to the school, one in which adolescents are brought from school to health facilities, and one control arm with no linkage between school and health facilities. The intention is to assist the Ministry of Health and the Ministry of General Education to scale up the model that demonstrates the best results in increased integrated SRHR/HIV service uptake and improved adolescent SRH indicators. The intervention involved a baseline study of student SRH knowledge, attitudes and practice, and training of teachers and health care staff from the intervention sites in CSE and adolescent health linkages. It has also involved sensitization of school heads, parent-teacher associations and community members and leaders to generate a supportive environment for meeting adolescent sexual and reproductive health needs. With strong government ownership, this is a strategic intervention that has potential to contribute to reducing teen pregnancies and HIV acquisition. Twenty-three schools and related health facilities are involved in Solwezi and Mufumbwe districts of North-Western Province, with results expected in 2020.[118]

Policy coherence and multi-sectoral coordination mechanisms

The third intervention under the output for CSE is supporting national and provincial level policy coherence and multi-sectoral coordination mechanisms for youth health and development programmes (RF). The contributions in the 8CP have been influential in achieving positive changes. At policy level, UNFPA undertook extensive advocacy for the development of the Marriage Bill (COAR, KI interview) that seeks to harmonise the age of marriage across all categories, because child marriage, mainly of girls, remains widespread. The bill was still pending approval at the time of the CPE. The earlier law, the Marriage Act of 1964, stipulated marriage with parental consent for those aged 16-21, and without consent from age 21. However, over 30 per cent of girls in Zambia are married before age 18, and 6 per cent aged under 15.[119] From 2017, the CO also undertook high level advocacy to revise the minimum age of consent for young people to access SRH information and services. The age of consent has been a major barrier for younger sexually active adolescents to access integrated SRH/HIV services and allows health care providers to turn them away (KI interviews, document review). After wide consultation during the 8CP, at the time of the CPE a proposal had been submitted to the Ministry of Health for approval by the Permanent Secretary (KI IP and CO interviews). UNFPA contributed to several mutually reinforcing policies and guidelines during the 8CP, including the Adolescent Health Strategy, and others that relate to child marriage and SRH service integration (in addition to changes to in and out-of-school CSE curricula noted above).

UNFPA has provided technical and financial support to engage many multi-sectoral stakeholders through national and sub-national coordination mechanisms to formulate age appropriate SRHR information and related services to reach out-of-school as well as in-school young people as noted earlier (document review, KI interviews). The core mechanisms that UNFPA

[116] ICF (July 2018) End Term Evaluation of the Project Strengthening Comprehensive Sexuality Education for Young People in School Settings in Zambia, 2013-2018.
[117] Population Council (2018) Project Implementation Report on developing a model to strengthen linkages between CSE and utilisation of appropriate health services by adolescents in Zambia
[118] UNESCO Annual Progress Report (2018) on the project: Strengthening comprehensive sexuality education programmes for young people in school settings in Zambia, 2013-March 2019
[119] https://www.girlsnotbrides.org/child-marriage/zambia/

supports for policy coherence and coordination at national and provincial levels include regular participation in the bimonthly Adolescent Health Technical Working Group (TWG) and, in the three focal provinces, the sub-offices help facilitate bimonthly meetings of the provincial adolescent TWGs, with financial support from SYP.[120] In Lusaka and Copperbelt, the MDGi has likewise assisted. Importantly, the focus also includes youth organisations as well as others from civil society, holding to the principle of 'nothing for us without us', a human rights and people-centred approach and in line with the UNFPA SP. A harmonised, standardised package on ASRH was being finalised through the national level Adolescent Health TWG at the time of the CPE that is aligned to the Adolescent Health Strategy 2017-2021. Also, to strengthen access to and uptake of integrated SRHR services, UNFPA is collaborating with Planned Parenthood Association of Zambia (PPAZ) to engage empowered young people from youth networks to advocate with parliamentary committees for increased financial allocations for adolescent health, particularly SRHR (KI interviews, document review). This includes institutionalising a mechanism for youth networks to make formal submissions on SRH service delivery for young people and to ensure the implementation of commitments. Strengthening the capacity of youth networks and engaging them in special events, such as international youth day activities, has also been an important activity supported by UNFPA that raises both the confidence and capacity of youth as their own advocates, and the public and political perception of their capacities and importance as a cohort to address seriously - and to whom far more resource allocation is needed to achieve or realize the demographic dividend of the youthful population. The evaluators considered it highly appropriate that the CO has employed a UNV with the specific role of supporting youth empowerment.

Strategies and programmes to end child marriage, address teen pregnancy and end gender based violence

The second output of the 8CP is increasing the capacity of national, provincial and district institutions to design and implement comprehensive programmes for marginalized adolescent girls, including safe spaces, for those at risk of child marriage (RF). In 2016, with advocacy and support from UNFPA and other partners, the National Strategy to End Child Marriage was launched and disseminated, with further action to develop a linked national plan of action. Further, specific district action plans in the intervention districts have been developed with the support of the Global Programme. UNFPA has successfully contributed to district ownership through the development of these action plans, Child marriage is defined as the marriage of anyone below age 18, although by far the most adolescents in child marriages are female.[121] Early marriage jeopardises their access to education and hence later employment, and exposes them to early pregnancy and risks of fistula and maternal mortality, as well as often being forced. The first intervention in the RF for this output is to implement and monitor national strategies and community based programmes, such as child marriage free zones and effective community support systems with active male involvement, aimed at ending child marriages, addressing teenage pregnancy and ending sexual and gender based violence. GBV is mainly addressed in section 4.2.1 and 4.2.3, as interventions address GBV regarding all ages of survivors, but addressing GBV is also relevant in the prevention of child marriage programmes. The second intervention in the RF is to foster strategic partnerships to build social and economic assets of women and adolescent girls through safe spaces, and these overlapping interventions are both addressed here.

A lesson learned (COAR) at the start of the CP was the importance of taking a synergistic approach to addressing the SRH needs of adolescent girls, addressing child marriage together with integrated service provision for SRHR, HIV, GBV, CSE, adolescent friendly services, youth empowerment and asset building and leadership, as well as addressing an enabling environment at all levels. Programmes addressed above thus include a focus on ending child marriage as indicated, rather than child marriage being approached in isolation. For instance SYP addresses child marriage in the three focal provinces, with outreach to adolescents in the focal districts (mainly girls but to some boys also),[122] sensitization of parents, traditional leaders and other community members, and increasing engagement of GRZ.

Child marriage is also addressed in an integrated way through joint programming in one district, Katete, in Eastern Province and one, Senanga, in Western Province, as part of the Joint Global Programme on Ending Child Marriage. The completed first phase in North Western and Lusaka Province has been positively assessed as a potential good practice case study of a strong inter-agency programme,[123] with multi-dimensional, mutually reinforcing approaches to achieve results (KI interviews, document review), and with strong trust between partner organisations, including good personal relationships. Partnership was reported as particularly strong between UNICEF and UNFPA with early engagement in planning and design. Through

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[120] A budget of US$30,000 is reported to be provided to each province for coordination, capacity building, SBCC and peer educators through SYP (CO interview)
[121] The Policy Brief on Child Marriage in Zambia (June 2017) cites that among girls 15-19, 16.5% were married compared with 1% of boys.
[122] In 2016 the COAR indicates a ratio in the region of 10 girls per single male
[123] UNFPA/UNICEF (2017) Child Marriage: A Child Marriage Mapping of Programmes and Partners in Twelve Countries in East and Southern Africa, Nairobi, Kenya

the YWCA, UNFPA and UNICEF have partnered throughout the 8CP with GRZ and others to develop safe spaces for marginalized young people, particularly girls, with a systematic mentorship programme that assists adolescent girls, including a small number with disabilities,[124] although there has not been sufficient outreach to address adolescents with special needs. Some results are encouraging: for example, at a high school in Senanga a 41.7 per cent reduction in teen pregnancy was documented in 2018 (KI interview, document review). Field work during the CPE (KI interviews, beneficiary FGIs and document review), did not find significant results regarding economic empowerment, however, although social and economic asset building was a key part of the programme.

Accountability mechanisms to enforce legislative and policy actions on the legal age of marriage, and improving access to SRH[125] services

The third intervention in the RF is to design accountability mechanisms to enforce the legal age of marriage and improve SRH service access. This has involved high level dialogue with parliamentarians, and UNFPA contributed to the development of legislation and policy in the previous CP as well as, during the 8CP, supporting the Ministry of Gender to develop the National Strategy on Ending Child Marriages 2016-2021. The legal age of marriage in Zambia is 18 with parental consent and 21 without parental consent, but Zambia has parallel legal systems, customary and statutory and, within customary law, child marriage is acceptable at a young age and even encouraged (e.g. if a girl becomes pregnant she may be sent to the household of the father in the expectation of marriage, according to KI interviews and document review). Thus the efforts of UNFPA through the end child marriage programmes focus on changing traditional attitudes to follow statutory law over customary law in this regard. The SYP and 2gether 4SRH programmes noted earlier include this focus to protect adolescent girls from early marriage and to increase their access to and uptake of SRHR services, including extensive mentoring of young people. One appropriate initiative in 2018 was expanding engagement to the national House of Chiefs and, in 2019, reaching provincial councils of chiefs. That programming has reached a far higher number of traditional leaders in the 8CP than initially targeted (1864 over 50) is indicative of the understanding that it is essential to change community perceptions regarding not just child marriage, but adolescent access to full SRHR services given how many parents oppose this (COARS and KI interviews). To make mentoring more acceptable to parents, programming was widened to include wider adolescent health issues (COARs).

4.2.3 To what extent has the programme mainstreamed gender and human rights-based approaches, including for people with disabilities?

Summary

Addressing gender equality and the empowerment of women (GEEW) has been prominent in 8CP engagement and in previous CPs, each building on previous work. Gender is mainstreamed across the thematic areas in several modes of engagement as part of a human rights approach that underlies all programming, including efforts to reach those in most need. Rights based language is not apparent, however, and could usefully be employed.

The focus on disability is less well developed but has increased during the CP with the intention to strengthen this focus in coming years. A joint project on disability and SRHR has been initiated in one province.

The cross-cutting issues of gender, disability and a human rights approach are fairly well evidenced in the 8CP, although they can be developed further. Gender mainstreaming appears relatively well established in 8CP programmes with regards health provider training, sensitization of chiefs and headmen in gender transformative approaches regarding GEEW and harmful gender norms, SRHR programming including for adolescents and youth, in facility reporting and in data disaggregation in the population dynamics component. However, although facilities document detailed age and sex disaggregated data at the sites visited (review of registers and reports, KI interviews), at district level much of this information is summarised and not disaggregated, thus losing the potential for more specific tailoring of programming to the greatest needs of different age groups and by gender.

Women are well represented within the UNFPA CO and sub-office staff complements, and a gender analyst is in place. The staff member links actively with the Ministry of Gender on gender responsiveness overall, in particular with regards GBV and child marriage. UNDP calculates the Gender Inequality Index and UNFPA contributes with respect to integrated SRHR. GBV is addressed in section 4.2.1 and is not repeated here, except to emphasise that the achievement of justice against perpetrators of GBV, primarily intimate partner violence, lags far behind the positive health response to survivors of GBV in the health

[124] One mentor can reportedly utilise sign language to work with girls with hearing impairments (COAR)

[125] The RF uses the term sexual and reproductive health, SRH, not sexual and reproductive health and rights. The CPE mostly uses the term SRHR except, for example, where an explicit reference to rights is linked with SRH, and in specific documentation and project titles that use SRH, not SRHR (e.g. 2gether for SRH).

facilities. The focus on child marriage is premised on a human rights approach to vulnerable adolescent girls, including young adolescents.

Addressing the integrated SRH needs and rights of the most vulnerable, including people with disabilities, marginalized women and girls and their partners, women with fistula and others, is also evidence of a human rights perspective. Likewise, UNFPA selected provinces and districts with poor SRHR indicators as the priority for interventions, indicating the intention to reach those most in need. Specific rights-based language is not generally apparent in the documents reviewed, for instance in terms of rights holders, duty bearers and gatekeepers, and it might be useful for the CO specifically to adopt this framework. Nonetheless, the entire orientation of the UNFPA CP supports the realisation of rights to SRH including for safe motherhood, family planning, HIV prevention, for adolescents, around GBV and for the empowerment of women.

UNFPA has begun to focus on people with disabilities in a variety of ways, although this is a focal area that the CO acknowledges is lagging behind and wishes to strengthen in the next CP (CO interviews and document review). This includes recognising the need for strengthened data on people with disabilities. The upcoming census in 2020 includes a range of questions to document different types of disability nationwide that should provide valuable quantification for further programming, building on the UNICEF-supported National Disability Survey of 2017. CO feedback indicated that UNFPA involvement in the survey was limited to validation level. However, a key area of strategic support by UNFPA is changing attitudes to disability in the communities and among health staff. Traditionally, disability has been seen as a curse caused by witchcraft or wrongdoing, and the birth of a child with a disability brought shame on the family (KI interviews).

A new project began in two districts (Mansa and Samfya) of Luapula Province in September 2018[126] where UNFPA is collaborating with ILO on the promotion of disability inclusion in multi-sectoral ways. The involvement of UNFPA is on promoting disability inclusion for integrated SRHR, HIV and GBV services, while ILO concentrates also on social and economic vulnerabilities (KI interviews, document review). Among other initiatives, sensitising and educating chiefs, headmen and local religious leaders is being addressed through workshops that include people with disabilities in Luapula, and this is likely to make a difference to community attitudes and perceptions (KI interviews with IPs and beneficiaries). The intended outcomes of the project are to provide disability inclusive services through: training modules for nurses and midwives piloted at Mansa Nursing College in late 2019 (90 participants); knowledge and skills strengthening on disability among 28 SRHR and HIV health service providers and raising awareness in men, women and young people with disabilities of their SRH, HIV and social protection rights and how to claim them.

Health staff sensitised on disability were aware of the need to provide for the SRH and rights of people with disabilities to access information and services, and expressed motivation to reach them. UNFPA support for the identification of and treatment for women with obstetric fistula, as addressed above, can also be viewed as a positive response to a pernicious form of disability that had been largely neglected in the past.

At the initiation of the RMNCAH&N programme in Western and Central provinces, the UNFPA-UNICEF technical team developed a position paper for mainstreaming human rights, gender and disability into health programmes.[127] Thirty people with visual impairment and health care providers from the two provinces attended a five-day workshop to enhance their capacity regarding SRHR for people with disabilities. This aimed to increase awareness in people with disabilities around SRHR and related service access, and to improve the provision of disability sensitive services by health care providers. A workshop report set out agreed actions to strengthen linkages between communities and health facilities for people with disabilities that led to the Ministry of Health, with UNFPA support, developing modules on disability to incorporate in nursing and midwifery curricula. During field work for the CPE, however, no facilities visited or staff catered effectively for people with motor, hearing, visual or mental impairments (site observation and KI interviews), despite positive attitudes expressed towards including people with disabilities in their services.

UNFPA has funded and brought together people with disabilities[128] from the three provinces of Western, Lusaka and Central in sensitization workshops on SRHR. The adolescent health strategy[129] to which UNFPA contributed financially and technically in the 8CP includes a focus on adolescents with special needs, but acknowledges that little is known about the

[126] Promotion of Disability Inclusion in Integrated SRHR and HIV with financial support from the UNPRPD Disability Fund
[127] UNFPA (2019) RMNCAH&N 2018 Annual Report
[128] Each workshop included people from the three provinces with the same type of disability, i.e. visual or hearing or mobility impairments.
[129] MoH (2017) Adolescent Health Strategy 2017-2021

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numbers of male or female adolescents with different disabilities, and a great deal more is needed to ensure their realisation of all human rights including access to SRH information and services.

During the 8CP UNFPA also supported the Library for the Visually Impaired to develop and disseminate braille materials on SRHR and HIV to 69 focal libraries throughout the provinces. Although this is reported (KI interview) to be greatly valued by people with visual impairment, throughout the field work no link with or knowledge of the libraries was found, nor access to braille materials, so the impact of the materials could not be assessed. The main beneficiaries who can read braille are highly unlikely to be people with visual impairment in rural communities, but ensuring positive attitudes in the community and among health facility staff facilitates their discussing SRHR with people with visual and other impairments.

4.2.4 To what extent did UNFPA contribute effectively to data generation and sustained increase in the use of disaggregated and evidence-based demographic and socio-economic data in policies, planning and programming?

Summary

UNFPA 8CP contributed to strengthened national policies by advocating and supporting the revision of the National Population Policy until its eventual approval by GRZ Cabinet. Utilising the demographic dividend study findings to inform the development of the 7NDP, UNFPA contributed effectively to the use of disaggregated and evidence-based demographic and socio-economic data in plans.

Through sub-national analysis introduced in this CP, UNFPA has built capacity in data generation, analysis and utilisation of disaggregated evidence-based data to inform plans at provincial and district levels. All these efforts have contributed significantly to strengthened capacity and availability of data to inform development plans, particularly around areas of the UNFPA mandate.

UNFPA also contributed significantly to the focus on empowering women and young people through support for relevant information products for parliamentarians and policy makers as well as for the beneficiaries themselves.

The outcome of the 8CP on the population dynamics component was to be achieved through Output 1 implemented through three areas of intervention: first, evidence-based advocacy for integration of population variables in the 7NDP and sector policies, programmes, budgets and expenditure frameworks; second, capacity development of national, provincial and district level institutions to undertake data generation, in-depth analysis and utilisation of disaggregated data by age, sex, wealth quintile and geographic location, to inform national development processes, including humanitarian preparedness and response; and third, empowering women and young people to engage in policy dialogues on rights of women and young people in national development processes. The inputs of UNFPA during the 8CP have been extensive, including advocacy and policy dialogue, capacity development, knowledge management, and working through coordinated partnerships.

Achievement of results

The table below summarises the achievements against the 8CP Outcome 4 and output 1 indicators of the population dynamics component. As shown in the table, the UNFPA CO fully achieved the set CPD targets for the first and second indicators of Outcome 4. Excluding the baseline, the UNFPA CO contributed to the achievement of 20 national statistical publications with disaggregated data on sexual reproductive health by age, sex and wealth quintiles. For the second outcome indicator, the UNFPA CO contributed to the achievement of eight national development plans and sector policies incorporating population dynamics, excluding the baseline. For Output 1, five provinces had capacity developed to collect, analyse and use disaggregated data to inform plans, policies, and programmes. The set target for the first indicator is likely to be achieved by the end of the 8CP. The set CPD target for the second Output 1 indicator has been fully achieved. The UNFPA CO supported 13 in-depth analysis reports generated with disaggregated data sets for SRHR. The achievements in the table indicate that the UNFPA 8CP Output 1 contributed to achieving Outcome 4 in strengthening national policies and plans integrating evidence-based data on population dynamics, SRHR, HIV and gender equality. Also, the UNFPA CO contributed to achieving Output 1 of the 8CP by supporting capacity development in data generation, analysis and the use of disaggregated data to inform policies, plans and programmes at sub-national level as well as generation of in-depth analysis reports with disaggregated data sets on population dynamics and SRHR.

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Table 9: Zambia CPD M&E Matrix Results for Population Dynamics in 8CP, 2016 - mid 2019

Indicator	CPD Baseline	CPD Target	Achieved				Progress against CPD targets
Outcome 1: Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality							
			2016	2017	2018	2019	
# of national statistical publications with disaggregated data on sexual reproductive health by age, sex and wealth quintiles[130]	3	**6**		**7**	**12**	**1**	**23: Achieved**
# of national development plans and sector policies incorporating population dynamics	6	**10**	**2**	**3**	**3**		**14: Achieved**
Output 1: Increased availability of disaggregated evidence through cutting-edge data generation and in-depth analysis of population dynamics, sexual and reproductive health, HIV, and gender-equality outcomes							
# of provinces with capacity to collect, analyse and use disaggregated data to inform plans, policies and programmes	0	***6***	2	2	1		**5: Likely to be achieved by end of CP**
# of monographs and in-depth analysis reports generated with disaggregated data sets for sexual reproductive health, including in humanitarian preparedness and response	5	**15**	7	3	2	1	**18: Achieved**

Note: Numbers in brackets are non-cumulative and those not in brackets are cumulative

Linking the results framework and the achievements of the population dynamics component, there are clear baselines, measurable targets and indicators that enabled Output 1 to be achieved and contributed to SP Output 4 results. However, the achievements of the population dynamics component go beyond the two intervention areas reflected in the indicators of Output 1. Achievements for the third key intervention on empowering women and young people to engage in policy dialogues on rights cannot be clearly measured by the two indicators of Output 1. There is need for the results framework to accommodate indicators that could to some extent measure achievements in advocacy and policy dialogue as well as performance in dissemination of population dynamics issues.

Capacity development for data generation and in-depth analysis

The first intervention in the RF for population dynamics is capacity development of national, provincial and district level institutions to undertake data generation, in-depth analysis and utilisation of disaggregated data by age, sex, wealth quintile and geographic location, to inform national development processes, including humanitarian preparedness and response. During the 8CP UNFPA played a significant role in enhancing capacity in coordination and harmonization in the generation of statistical data in Zambia through the National Strategy for the Development of Statistics (NSDS).[131] UNFPA supported the CSO by successfully advocating for the adoption of the Statistical Act of 2018[132] to establish an integrated national statistical system that is now being implemented. Under the Act, the CSO is in transition to being reconstituted as the Zambia Statistics Agency (KI and CO interviews, document review).

To increase the availability of disaggregated evidence-based data at national level to inform policies, plans and programmes, UNFPA provided technical and financial support for preparatory activities of the 2020 census undertaking in response to the limited capacity of the CSO in data generation (KI and CO interviews and document review). Specifically, UNFPA supported the following activities: development of the strategic 2020 census implementation plan, questionnaire design,[133] validation and finalisation, stakeholder consultative meetings, a census technical advisor; and procurement of 2020 census mapping software, motor bikes, mapping field supplies, and shipment of tablet computers (about 15,000 tablets) from Malawi (KI and CO interviews). The CO financially supported the 2020 census pilot mapping in Chongwe and Lusaka in January and February, 2019 (CO and KI interviews and document review). Owing to limited resources, the census mapping exercise has only been completed in Lusaka province, consequently delaying the main pilot census which was scheduled for 16th August 2019 to

[130] Initially, the first indicator was written as "proportion." It has been changed to "number" due to lack of a clear denominator.
[131] Central Statistical Office. 2014. National Strategy for the Development of Statistics
[132] Statistics Act 2018. https://www.zamstats.gov.zm/phocadownload/Dissemination/The%20Statistics%20Act%202018.pdf
[133] Central Statistical Office. 2019. Background to the 2020 Census Questions

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coincide with the actual 2020 census date (KI interview). To complement constrained GRZ resources for the 2020 census, the CO leads the partnership and coordination of stakeholders and donors in resource mobilisation (CO interviews).

UNFPA financially and technically supported the 2018 Zambia Demographic and Health Survey (ZDHS) activities such as questionnaire finalisation, publicity, survey fieldwork supplies, coordination and dissemination of the preliminary report, in-depth analysis and current drafting the final report for publication in early 2020 (KI and CO interviews and document review). This contributed to enhancing evidence-based data generation to inform policies, plans and programmes.

At sub-national level, UNFPA played a key role in data generation and in-depth analysis, utilisation and integration of population dynamics into policies and programmes as part of NSDS and 7NDP implementation. In 2016 and 2017, UNFPA CO financially supported CSO to build capacity of provincial planners in disaggregated data analysis and in-depth analysis of the 2010 census data that is informing plans and programming in five provinces (Eastern, Luapula, North Western, Southern and Western) (KI and CO interviews and document review). There is need, however, for a consistent, clear tracking system on utilisation of the acquired knowledge and skills by planners at national and sub-national levels.

During the 8CP, UNFPA also supported sub-national analysis profiles initially in Luapula, Central, Copperbelt and Lusaka provinces, and in 2018 included all provinces. The sub-national analysis was based on key socio-economic development (health, education, standard of living, child mortality, child marriage) and SRHR (maternal mortality) indicators using the Multi-dimensional Poverty Index (MPI).[134] Geo-spatial map profiles of all provinces, districts, constituencies and wards for key socio-demographic and economic indicators were generated and ranked by performance from the best to the worst performing.[135] By the time of the CPE, the profiles had been disseminated to 92 members of parliament and key stakeholders in six provinces (Central, Copperbelt, Eastern, Luapula, Lusaka, and Western) (KI and CO interviews and document review). Dissemination was yet to take place in Muchinga, Northern, North-Western and Southern provinces. The sub-national profiles are appreciated and utilised for evidence-based decision making and development planning, and equitable allocation of resources and targeting of interventions in priority wards based on the rankings of inequality and vulnerability (KI and CO interviews, document review). The geo-spatial map profiles of the key indicators have been useful to policy-makers (KI and CO interviews). The sub-national analysis contributed to the 8CP output by increasing provincial capacity to collect, analyse and use disaggregated data to inform development plans and programmes. For instance, in Luapula province a district development plan for Chembe was shared with the evaluation team.[136]

CSO staff were provided financial support to attend relevant international and regional training workshops and study tours to develop their capacity. Examples included: a Malawi census study tour; REDATAM-based Integrated Management Information System (IMIS) in South Africa; CSPro Android and Computer Assisted Personal Interview (CAPI) using tablets in South Africa; the United Nations Statistical Commission meeting in New York in 2016; a GRID workshop in Senegal; a census and SDGs workshop in South Africa; and a data dissemination platforms workshop in Ethiopia (KI and CO interviews and document review). This enhanced staff capacity in data generation and in-depth analysis of population dynamics and use of cutting-edge technologies to increase the availability of evidence-based data.

UNFPA also contributed to increasing demand for geo-referenced data for evidence-based decision-making and development planning through the Geo-Referenced Infrastructure and Demographic Data for Development (GRID3) programme. The CO provided technical and financial assistance in the development of a national road map on the collection, use and management of geo-spatial data (CO interview and document review). In March 2019 UNFPA financially supported the Surveyor General's Office (National Spatial Data Infrastructure, NSDI)) to hold a workshop on sub-national boundary harmonization with key stakeholders (CSO, Electoral Commission of Zambia, and Ministry of Local Government) to address misalignment of administrative boundaries and facilitate generation of accurate statistics at different administrative levels (KI and CO interviews and document review). KI interviews indicated that there was political will and consensus among key stakeholders, resulting in completion of harmonized district boundaries. At ward level, the process of harmonizing boundaries was more complex with challenges over the actual boundaries in some places (KI interview and document review). The process was still continuing at the time of the CPE.

UNFPA has also financially and technically supported the development of a geo-referenced model to drive population estimates to validate the 2020 census results, and development of geo-referenced Use Cases to determine targets and specific

[134] Ministry of National Development Planning and UNFPA. 2016. Sub-national population situation analysis for national development planning in Zambia
[135] Ministry of National Development Planning. 2018. The sub-national analysis report
[136] Chembe District Strategic Plan 2017-2021

development needs (KI and CO interviews and document review). This will result in increased demand for geo-referenced data to inform development plans in the integration of geo-referenced boundaries, population settlements, roads, underground infrastructure, and with a link to the attainment of the SDGs (KI and CO interviews).

To build capacity in geo-referenced data utilisation, the CO financially and technically supported local training workshops for staff from IPs and partner institutions in the Geographical Information System (GIS) and Small Area Estimation (SAE). This resulted in development of a GIS training module for national institutions. UNFPA also supported IPs to attend international and regional travel for meetings and training workshops: United Nations Committee of experts on geo-spatial data in New York; an Earth observation and SDG linkage programme in Hungary; and Use Case workshop in Nigeria (KI and CO interviews). The capacity of NSDI was enhanced through procurement of GIS software and license, and technical assistance for the geo-reference infrastructure platform by UNFPA (KI and CO interviews). The knowledge and skills gained from the meetings and training workshops are being effectively utilised in the development of Geo-spatial Use Cases and in the boundary harmonisation process (KI interviews and documentation).

Although the MNDP-PDD has adequate staffing (KI interviews and document review) to address CP activities, financial support to recruit programme associates, that is staff at entry and middle levels, would be useful. KI interviews found that staff changes and transfers at MNDP and the CSO have disrupted established working relations and overall staff capacity, requiring revision of signatories and capacity building of new staff. UNFPA is investigating sourcing funds for an international long-term expert for the CSO for the upcoming Census 2020 (CO interviews).

Evidence-based advocacy for integration of population variables

The second intervention of the RF is evidence-based advocacy for integration of population variables in the 7NDP and sector policies. As the key UN supporter and advocate of the integration of population variables into policies and plans, UNFPA played a key role in strengthening national policies by advocating for the revision of the National Population Policy and development of an implementation plan. The UNFPA CO financially supported the holding of consultative meetings and engagement of a technical consultant for the revision of the National Population Policy (KI and CO interviews and document reviews). The Revised National Population Policy has since been approved by Cabinet and the next stage is dissemination and implementation (KI interviews). The Revised National Population Policy took a new approach, providing an overarching policy framework for all sectoral policies for reference in the integration of population variables in development plans, in order to harness the demographic dividend (KI and CO interviews).

In addition, to ensure integration of evidence-based analysis on population dynamics in national plans, UNFPA provided financial and technical support to the Population and Development Directorate of the Ministry of National Development Planning (MNDP - PDD) to develop the Seventh National Development Plan (7NDP).[137] Document reviews and KI and CO interviews indicated that the Demographic Dividend (DD) Study[138] funded by UNFPA generated the evidence that informed the development of the 7NDP. Also, the Rapid Country Profile[139] of 2017 was critical in providing baseline information and projections for the 7NDP. The pillars of the 7NDP were adapted from the DD study wheels or areas of focus in optimising the benefits of the DD (KI and CO interviews), ensuring that population issues were well integrated in the 7NDP. The human development pillar in the 7NDP, with its indicators, is based on the DD study. UNFPA support was therefore effective and contributed significantly to the 7NDP, especially the implementation plan (Volume II) (KI and CO interviews).

In 2018, the UNFPA jointly with UNICEF and UNDP financially and technically supported MNDP in the mainstreaming process of SDGs into the 7NDP, resulting in the development of the SDGs Coordination and Implementation Framework 2017-2030[140] (KI and CO interviews and document review). The mainstreaming involved mapping and alignment of SDG targets with the 7NDP pillars. A Rapid Integrated Assessment[141] of the national SDG indicators found that out of 230 SDG indicators, only 69 indicators have data available, 168 indicators are available and 121 indicators need to be developed (KI and CO interviews and document review). Through the SDG Coordination and Implementation Framework, the UN financially supported the Central Statistical Office (CSO) to develop the 2018 SDG Indicator Baseline Report to enhance the

[137] Ministry of National Development Planning. 2018. 7NDP Implementation Plan 2017-2021. Volumes I and II
[138] Ministry of Finance.2015. Harnessing the Demographic Dividend: The future we want for Zambia
[139] United Nations-Zambia.2017. Rapid Country Profile
[140] Ministry of National Development Planning and United Nations-Zambia. 2018. Zambia SDGS Coordination and Implementation Framework 2017-2030: Zambia SDGS road maps: A Guide to Implementation of Sustainable Development Goals 2017-2023
[141] United Nations - Zambia. 2019. Rapid Integrated Assessment of Zambia's Seventh National Development Plan (2017-21) Volumes 1 & 2

monitoring and reporting of SDGs in Zambia (KI and CO interviews and document review). This contributed to the 8CP outcome of strengthened policies and plans that integrate evidence-based analysis on population dynamics, SRHR, adolescent and youth, HIV and gender equality at national and sub-national levels.

The 8CP supported the commemoration of global and regional events, such as World Population Day, launch of the State of the World Population report and African Statistics Day (KI and CO interviews and document review). This ensured that the momentum in advocacy and policy dialogue around population dynamics, SRHR, HIV, and gender equality was sustained.

In 2018, MNDP-PDD with UNFPA financial support conducted a national review of Zambia's performance 25 years since the International Conference on Population and Development (ICPD+25) and the 5-year review of the Addis Ababa Declaration on Population and Development (AADPD+5) across the six AADPD pillars (KI and CO interviews and document reviews). The review recommended development of a comprehensive framework to monitor, evaluate and report on ICPD/AADPD commitments and indicators (KI interview).

UNFPA financially supported MNDP-PDD staff for international travel to participate in the United Nations Population and Development Commission meeting in New York; a population and development review meeting in Addis Ababa, Ethiopia; and a study tour to Kenya to learn how the population policy is being implemented there (KI and CO interviews). The knowledge gained from the study tour informed the revision of the National Population Policy (IP and CO interviews).

Empowering women and young people to engage in policy dialogues on rights

The third intervention of the RF is to empower women and young people to engage in policy dialogues on the rights of women and young people in national development processes. Throughout the 8CP, UNFPA played a key role in enhancing engagement in policy dialogue on the rights of women and young adolescent girls. The CO financially supported Population Council to generate knowledge management products and develop policy briefs for parliamentarians and policy makers that influence dialogue and inform evidence-based policy, programme development and quality SRHR and ASRHR care and service delivery (KI and CO interview and document review). The policy brief on child marriage provided evidence for advocacy, policy dialogue, leadership engagement and parliamentary debates on changes in the Marriage Act, rights of the child and interventions to reduce child marriage. For example, the development of the National Strategy on Ending Child marriage (2016-2021) was informed by in-depth analysis of child marriage (KI and CO interview and document review).

As addressed in section 4.2.2 on adolescents and youth, UNFPA supported the development of a range of information material, including the State of the Youth Report that provided a comprehensive analysis of realities and challenges encountered by youth measured against the key national development indicators and identification of priority areas for intervention (KI interview and document review). The report informed interventions to safeguard adolescents and youth. Regarding knowledge management for young people, UNFPA developed SBCC[142] products and CSE programmes in order to increase young people's knowledge. UNFPA also provided financial support to youth capacity development which resulted in strengthened networks to advocate and meaningfully participate in international, regional and national decision-making platforms (KI interview and document review).

UNFPA supported critical thinking symposia with a wide range of stakeholders at national level and in the provinces of Luapula, North-Western and Western to enhance strategic partnerships and engagement, to influence utilisation of evidence and strengthen SRHR policy, and to analyse bottlenecks that impede programming (COAR, KI interview).

Document reviews show that reports produced with UNFPA support ensured data disaggregation by age and gender at national and sub-national levels, thus highlighting disparities in age and gender. This facilitated evidence-based programming in the 8CP to address gender inequality and SRHR among young women and men. UNFPA also provided technical and financial support for capacity development in the analysis and use of disaggregated data on GBV as well as on adolescents and youth (document review), to assist evidence-informed planning, programming and monitoring.

4.3: Efficiency

4.3.1 To what extent has UNFPA made good use of its human, financial, administrative and technical resources and used an appropriate combination of tools and approaches to pursue the achievement of the outputs and outcomes

[142] Social and behaviour change communication

defined in the country programme?

Summary
Overall efficiencies in the CO appear to have improved during the 8CP for a number of reasons but there is room for further improvement, particularly around financial disbursements.

4.3.1.1 Human and administrative resources

Overall, the CO has made good use of its resources during the 8CP. The office structure and typology have not changed substantially from the previous CP, including with respect to the three sub-offices that were down-sized during the 7CP to a coordinator, a programme assistant and one driver in each site. Their presence in the respective provinces (North-Western, Luapula and Western) was highly valued by the IPs interviewed at provincial and district level as having increased the efficiency of operations particularly through contributions to coordination and oversight. Staff skill sets appear generally appropriate to the five modes of implementation, with supplementation by several UN volunteers, and supervisory structures are clear.

A CO management audit by the UNFPA Office of Audit and Investigation Services (OAIS) for January 2014 to end of March 2015 rated several aspects of office governance, programme management and operations management partially satisfactory (CO interview, document review). CO interviews indicated extensive follow up to the recommendations for office governance, programme management and operations management, including several that are incorporated in the table in the following section (e.g. management meetings and the adoption of certain tools for reporting). Other reported areas of response include, for example, changes to the procurement process and more detailed quarterly reporting by implementing partners (seen in report review). In the framework of the CPE it was not feasible to do an in-depth review of all 26 audit recommendations, but various improvements to efficiencies are highlighted below. The decentralisation of office structure to the provinces was considered a good practice that should be shared with other offices, also the spreadsheet based consolidated annual plan matrix and maintenance of comprehensive human resource files.

On the programme side, of some concern to IPs is the lack of a substantive population dynamics specialist since the post was frozen in 2017 (CO interviews). This has reduced UNFPA capacity for this critical thematic area for which no other UN agency shares the mandate. The strategic response of the CO was for the Assistant Representative, a demographer, to lead on population dynamics with roles shared within the office, and recruitment of a United Nations Volunteer (UNV) population dynamics analyst from the third quarter of 2019. Nonetheless, several IPs (KI interviews) expressed concern at the lack of a full-time PD specialist because it appears to have reduced consistent engagement in high level technical discussions (see EQ2). Although population dynamics interventions and outputs were extensive, the findings are that consideration should be given to this post being unfrozen. Another gap was the lack of a Deputy Representative for almost a year, addressed by having three inter-office short-term placements from other COs. A new Deputy Representative came on board in September 2019, an important addition to consistent senior management. The CO is increasing the staffing complement through a £9 million grant from DfID, by seven new posts.[143] Remaining funds will contribute to programme implementation (and 8 per cent to indirect and administrative costs). This should further increase the efficiency and effectiveness of the CO in Lusaka and strengthen provincial staffing, and appears well justified.

To gain an impression of staff satisfaction at work and of perceived office efficiencies and challenges, a questionnaire was distributed to all office staff except senior management. This achieved a 78 percent response rate including CO and sub-office staff. Some key findings were that: the general office atmosphere was deemed fairly but not very positive, with room for improvement; supervision was positively rated; most saw their work-life balance as satisfactory; and a small majority reported that the frequency of interruption to their work was manageable although, for several, urgent requests from HQ, ESARO or from other office teams or units were deemed excessive.[144]

Importantly, the majority considered that office efficiencies needed to improve regarding operations, administration and finance, with need to strengthen the staffing complement and/or delegative efficiency to reduce delays regarding financial disbursements and other programming needs. Issues raised also included excessive bureaucracy with lengthy financial systems,

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[143] Programme coordinator, provincial coordinator, two provincial programme analysts, finance associate, programme associate, communications assistant, programme driver

[144] A significant limitation to the questionnaire is that it was entirely anonymous, limiting interpretation of findings and with no scope for follow up.

bottlenecks and lack of delegative authority if the appropriate staff member was out. The new typology with increased posts, greater attention to handover including delegative authority during staff absence and improved use of online systems should improve efficiencies. Delays were also due to incomplete compliance by programme staff with the requisite information needed for disbursements (CO interviews). Many staff wanted more skills building, including around systems and technical areas, for which a small budget from HQ would be required. Roughly half felt their skills were insufficiently utilised and further exploration of this might be useful (e.g. around RBM).

Internal communications were given variable ratings, both within and between teams, and suggestions were to improve the efficiency of in-house meetings and institutionalise on-line communications platforms for routine information sharing. Having quarterly staff meetings and weekly management meetings appears sufficient, and the frequency of team meetings was reported to vary widely from team to team. With regards new staff, it appears that induction processes need to be given greater attention as only one member rated their induction as good.

The experience of the evaluation team was that it was challenging to interview staff timeously as they were frequently unavailable because of commitments in or outside the office. Although most staff indicated a good work-life balance, the overall work pressures appeared high, particularly on more senior post holders, justifying expansion of the office typology.

One incidental finding was that the CO operates to a certain extent with minimum paper usage as part of ‘greening the blue’, with staff having a monthly printing limit, although systematic office reuse of draft paper is lacking. Like other agencies it also has recycling bins, but observation showed that appropriate use was insufficient. Yet environmental issues linked with climate change are also important for women and for SRHR (as noted by the ESARO Director Julitta Onabanjo).[145] For example, if rainfall is less predictable with more extreme weather patterns, women may be affected by having to travel further to access water, food sufficiency may be weakened if crops are at increased risk from drought or flooding, and access to essential services such as for EmONC and wider SRHR may be threatened. In any case, corporate responses to the threat of climate change need to be taken seriously given the global urgency.

4.3.1.2 Financial management

Financial management and systems appear robust (CO interviews, documentation and some on-line review), with close tracking of budgets and expenditures through the Global Programming System (GPS) and Cognos. The financial management dashboard, which covers all financial transactions and ledger for the whole CO (including for Lusaka and the sub-offices), is reported to be monitored weekly with exceptions corrected on a timely basis. This is evidenced by the financial performance review which is deemed (KI interview) to be consistently good and improving, having never had a red rating and often at 100 per cent. The evaluators did not have full access to online systems to verify this aspect, however, and relied on CO interviews and some document review and extracted data.

Funds are reported only to be disbursed against authentic invoices from goods and service providers with strict adherence to organisational policies and procedures to ensure full compliance to accounting. The very detailed financial management dashboard interfaces with Atlas in real time, and this is reported to work well, with daily monitoring and routine follow up of any inconsistencies. Annual ratings for compliance are reported as above 98 per cent (the threshold for acceptability) for all years except for Quarter One in 2016, when compliance was 95 per cent indicating insufficient consistency. Overall, the annual averages are indicative of strong financial management throughout the CP.

The harmonised approach to cash transfers (HACT)[146] is fully in place with assurance activities (spot checks and audit) planned and implemented during the year. All 2018 HACT audits were unqualified and follow up of implementation of recommendations from HACT audits for 2018 was completed before the 30 June deadline. The CO is fully HACT compliant and is a member of the HACT Committee with the other common service agencies (UNDP and UNICEF). As noted in Chapter 3, implementation rates overall were high across all thematic areas, programmes and management throughout the CP (see Chapter 3 and annex for more detail).

With regards the timely distribution of funds to IPs, however, various concerns are noted. Across all thematic areas, IPs reported delays in the first quarter that frequently delayed activities, although planned activities still needed to be undertaken within a given time frame. As a result, IPs would plan few activities for the first quarter. An additional cause of funding delay

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[145] Reliefweb.int 3 September 2019
[146] Harmonised with UNICEF, WHO, UNDP and WFP

in 2019 occurred when UNDP introduced a host to host payment modality, with payments going directly to vendors' banks. Although this streamlined the process, challenges arose in establishing the correct way of entering vendor bank and branch codes. This was later corrected by UNDP but led to further delays in disbursements in the first quarter. UNDP sustains the treasury function, but CO interviews indicated the intention to enhance the enterprise resource planning system to include UNFPA reporting requirements. Section 4.3.2 addresses reporting issues further.

With regards population dynamics, a particular issue arose regarding procurement through the government units that resulted in delays and inflated pricing (KI interviews), negatively affecting the budget (for example regarding mapping for the 2020 census). Procurement by the CO could minimize these delays and avoid budget overruns.

4.3.2 To what extent are results effectively and efficiently measured and contributing to accountability in programming?

Summary
Measurement of results clearly contributes to accountability in programming, although the extent to which effective quality assurance takes place needs to improve.

During the first year of the implementation of the 8CP, slight revisions were made to the M&E framework in an effort to ensure measurable results. Table 10 below shows the changes made to the output on supply and demand of reproductive health commodities. The changes were informed by (i) findings from the Reproductive Health Commodity Supply Survey that tracks the proportion of health facilities with essential maternal and reproductive health medicines and modern contraceptives, and (ii) the adoption of the indicator on additional users at national level in alignment with FP2020 targets. The revised indicators have successfully been tracked and reported by the CO (KI interviews, document review).

Table 10: Changes to the 8CP Results Framework 2016-2020

Country programme outputs	Output indicators, baselines and targets	Revision
<u>Outcome 1: Sexual and reproductive health:</u> <u>Output 2</u>: National, provincial and district institutions have capacity to increase demand for and improve supply of life-saving reproductive health commodities and medicines, including modern contraceptives	➢ Number of public health facilities with at least seven life-saving reproductive health medicines and commodities in supported provinces *Baseline: 150; Target: 350* ➢ Number of new acceptors of modern contraceptives per year in supported provinces *Baseline: 500; Target: 750 National*	➢ Percent of public health facilities with at least seven life-saving reproductive health medicines and commodities in supported provinces *Baseline: 66%; Target: 88%* ➢ Number of additional users of modern contraceptives per year in supported provinces *Baseline: 238,000; Target: 900,00*

Overall monitoring and evaluation is fairly robust but needs further strengthening. Prior to March 2017 when a Monitoring and Evaluation Analyst was recruited, M&E functions were the responsibility of the Population Dynamics Specialist and backstopped by the Assistant Representative. The incoming post holder revised and finalised an existing draft M&E plan that has been fully operationalised during the remainder of the CP. This, plus various refinements to operational and reporting systems, has streamlined and increased the efficiency of M&E functions (KI interviews, document review).

All programme staff received certified training in results based management (RBM) and have contributed improved understanding and tracking of measurable and evidence-based results. The CO uses the Strategic Information System (SIS) on planning, monitoring and reporting that UNFPA adopted globally in 2014. The SIS links the global strategic plan to the country programme outcomes, outputs and indicators. The SIS also includes milestones that allow for tracking of progress towards CP output indicators and targets as well as the contribution of projects to CP objectives. Despite being reported as user friendly (CO interviews), SIS is reported to have a number of challenges. These include (CO feedback) that it has limited data visualization functions, no automation to link progress across quarters and years, and SIS is not linked with the GPS (Atlas system). Data from reports uploaded in GPS are manually inputted to SIS.

The table below indicates activities involved in planning, monitoring, evaluation and reporting in the CP. Mid-term and end evaluation are not mandatory for each cycle, and the end evaluation of the 8CP is the first evaluation since the 6CP.

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Table 11: Outline of Reporting and Quality Assurance Activities in the UNFPA CO

Type of Report/Activity	Frequency
Planning	
CPD and RRF	Every 4-5 years
CO Work Plan	Annual
CP Planning Matrix for M&E	Quarterly and annual
Work Plans with IPs including for joint programmes	Annual
HACT assurance planning tool (work plan figures from GPS)	Annual
Results Plan (integrates CP outputs and organisational effectiveness and efficiency (OEE), part of SIS	Annual Annual by Results Groups
UN Strategic Development Partnership Framework	Mid Term Review to 2018
Monitoring	
CP Planning Matrix for M&E Tool	Quarterly and annual
Programme review of CP	Monthly review meetings, quarterly with sub-offices, mid-year and annual
IP work plan monitoring	Monthly by CO IP manager and quarterly, mid-year and annual
Work plan Progress Report (IPs) narrative	Quarterly and annual from IPs
FACE form (IP) financial report, now e-FACE (on line)	Quarterly from IPs against quarterly milestones
SPOT checks with IPs undertaken by BDO Global accountancy firm (initially financial only, now programme also to link spending and results)	Minimum annual by CO, more often depending on risk assessment of IP
HACT assurances include SPOT checks and annual HACT audits	
IPs financial audit	Quarterly and annual Annual for those with large cash disbursement (over USD 250,000)
HQ management audit of CO	Every five years, 2016, next one due 2021
Financial management dashboard	Monitored weekly, summarised monthly and reflected as red, yellow, green. Always good and improving, often get 100%
Evaluation	
CPE to assess accountability in present CP and orient to next CP	Once every two CP cycles
Reporting	
Country Office Annual Reports (COARs)	Quarterly and annual
Workplan Progress Reports	Quarterly and annual by IPs
Donor reports: Dashboard according to donor requirements, uploaded by UNFPA	Depends on agreement with donor (range from quarterly to annual)
DaO reports	Semi-annual to RC

Compliance to the planning, monitoring and reporting structures is reported as generally high (CO interviews and document review) and improving. IP planning was reported, for example, (CO interview) as late in 2018 but stronger and more timely in 2019, with all plans approved and signed by February. The aim is to complete plans in December. The CO has mid-year and annual review meetings with IPs, and all IP work plans are aligned to the 8CP M&E framework and targets, contributing to the overall CP.

The CO activity budget and progress matrix measuring UNFPA outputs appears efficient, with monthly and quarterly review meetings and on line automated tracking of implementation rates in the GPS as noted earlier. This tracks the level of activity implementation by IPs and serves as a monitoring tool for IP managers to assess progress or lack thereof towards annual work plan results. The CO uses an offline matrix to track progress towards CP outputs, with activity and budget tracking of IPs undertaken by IP managers, and routine budget tracking of fund codes and IPs undertaken by management (KI interviews with management).

Despite considerable teething problems, the use of the on-line Global Programming System (GPS) by IPs, with training in e-FACE, is proving effective over time (KI interviews). Further training is planned in 2019, and continuous one-on-one support is provided as needed. The proportion of progress reports submitted on time rose from18 percent in 2018 to 42 percent in early 2019 (on line observation and KI interview) and continues to improve. In the fourth quarter of 2018, improved controls in the processing of e-FACE transactions (retirements and advances) were introduced. Funding for a quarter is now contingent on the submission of both acceptable progress and financial reports, whereas previously, the e-FACE alone (without the submission of the progress report) was allowable for funding disbursement (CO interviews). The CO is working with IPs to continue improving both timely planning and reporting.

Most IPs do not have dedicated, trained staff for M&E, and the quality of M&E among IPs needs to improve, particularly for government (IP reports, KI interviews). The CO incorporates RBM training into mid-year and annual reviews, but nevertheless further training is needed. IPs are compliant, however, in using UNFPA reporting tools and templates,[147] even if reports are sometimes submitted late. Some IPs, particularly in the health sector, indicate having a heavy reporting burden to different donors and for different programmes. UNFPA also collaborates with other agencies on reporting for joint programmes, results groups and data theme groups within the framework of delivering as one.

IP managers in the CO undertake quality assurance and approval of IP reports, with the M&E Analyst ideally ensuring standardisation across teams. In reality, reviewing all quarterly and annual IP reports is not feasible, however, particularly as the specialist manages two IPs herself. IP managers have received training from the University of Zambia on RBM tailored to UNFPA needs as indicated earlier, but an assistant to support M&E functions would nonetheless be useful.

Quarterly programme monitoring visits for quality assurance and validation of data reported by IPs in GPS need to be strengthened. Programme monitoring and data quality assurance visits/audits are reported (KI interviews in the field, in UNFPA CO and in sub-offices) not to occur at all regularly by UNFPA or by MoH partners. Provincial or district health offices undertake monitoring and quality assurance in facilities only when they have funds to do so, and it would be preferable for UNFPA routinely to budget for this.

In addition to standard, internal M&E across programming, external evaluations have taken place during the 8CP on three programmes: the Mid-Term Evaluation of the UNFPA Supplies Programme 2013-2020; Evaluation of H4+ Joint Programme Canada and Sweden (Sida), and Evaluation of UNFPA Support to the Prevention, Response to and Elimination of Gender-Based Violence and Harmful Practices.

4.4 Sustainability

4.4.1 How far has UNFPA successfully promoted national ownership regarding its programme areas (policies, increased capacity and budgetary allocation) and integrated SRHR/HIV/GBV into policy, planning and programming?

Summary

Government ownership has increased with regards legislation, policy and strategies, to which UNFPA contributed technical and financial assistance, and with increased capacity of midwives and other health staff and community volunteers, as well as the capacity of government to generate related population data. However, GRZ budgetary allocations to health remain too low, including for SRHR.

Integrated SRHR/HIV/GBV has been successfully incorporated into policy and planning, with strengthened MoH emphasis on primary health care and commitment to integrated service provision. Budgetary constraints impede the maintenance of health facilities.

The incorporation of CSE in school curricula as an examinable subject should contribute to sustained gains in the SRHR knowledge of adolescent girls and boys. In addition, training of health care providers and setting up of adolescent friendly health services, as well expanding access to peer educators and CBDs, should contribute long term to greater uptake of SRHR services among young people although high attrition of peer educators needs to be addressed.

The CO has successfully continued to promote national ownership around SRHR in a number of ways, building on achievements in previous programme cycles. UNFPA has provided funding and/or technical support to the development of several policies, guidelines and strategies, and promoted SRHR/HIV/GBV integration at policy, planning and programming levels (see 4.1 and 4.2). The latter included technical and financial support for the development of SRHR/HIV/GBV guidelines and of integration of adolescent friendly reproductive and other health services. The benefits of service integration are increasingly recognised by the MoH and its health providers as part of health systems strengthening, and this would be unlikely to have occurred without UNFPA leadership and support. This orientation should be a sustainable long-term change in health provisions. Roll out of the recently developed road map and training of community based distributors to provide intramuscular and subcutaneous DMPA[148] should also lead to increased community access to long-acting contraception over time.

Throughout its programming for integrated SRHR, HIV and GBV, UNFPA has been building the capacity of the public health system and also supported implementing partners who can complement GRZ services. Extensive national capacity development has also taken place regarding condom programming (such as quality assurance of male condoms, procurement

[147] Templates (document review) include workplan indicators, baseline, targets, actual value and, briefly, activities

[148] Depot Medroxyprogesterone Acetate

and supply chain management systems, and safe disposal of unused/unwanted contraceptives). Particularly with regards waste disposal, the development of guidelines is likely to lead to sustained improvement in practice.

UNFPA contributed to the training of nurses and midwives through provision of pregnancy models and other equipment, as well as sponsoring the training of individuals, and has introduced a focus on disability and SRHR into their curricula that should also lead to a sustainable result in how people with disabilities are included in service provision.

Capacity development of health staff has increased the complement of trained midwives, and of clinical officers, midwives and nurses able to provide adolescent friendly services, for the linkage of SRHR, HIV and GBV, for the full range of modern family planning methods, and for some to undertake abortions and post-abortion care. Training has also increased the number of surgeons who can undertake fistula repair. Bringing these services much closer to the communities in need should be a lasting contribution to improved SRHR services in under-served regions.

Long term results can be anticipated from curriculum development for comprehensive sexuality education from grades 5 to 12, with both a strengthened focus on sexuality and CSE being made examinable in grade 12. These efforts, and following through on the most effective model for linking schools and health services, should contribute to a sustained increase in SRHR knowledge among adolescent girls and boys and to higher uptake of SRHR services. In addition, it is to be hoped that the advocacy to lower the age of consent for SRHR will result in a more positive legal environment for adolescent access to services without parental consent, and help to ensure that health care providers do not deny SRHR services to younger sexually active adolescents. It will nonetheless remain essential to continue work with community members and health care providers to support adolescent SRHR.

The joint RMNCAH&N programme in Western and Central provinces may not yet have led to substantive sustainable results for health systems strengthening in these provinces, although it did train provincial and district teams in bottleneck analysis and built capacity for evidence-based planning and budgeting (KI interview, document review), and the health systems approach was reported to contribute to effective collaboration and buy-in from the MoH. As the revamped programme rolls out, it is likely to lead to significant sustainable results during the remainder of the 8CP and into the next CP. UNFPA has contributed to strengthening supply chain management of reproductive health commodities, including for forecasting and quantification and information management systems, and including capacity development of MoH staff. However the extent to which this will be a sustainable result is unclear given that MoH has not taken over this responsibility. UNFPA has also increased the reproductive health related equipment and commodities available in selected health facilities. While the continued procurement by UNFPA of FP methods at the current level (around 50 per cent of national needs) is not sustainable, UNFPA is actively involved with GRZ to develop a business plan for increased domestic funding. This remains a fragile area, however, as advocacy for increased health spending has not been highly successful. The current health budget was reported (MoH KI interview) to have remained at 9 per cent of the national budget throughout the 8CP, despite the Abuja Declaration commitment to 15 per cent financial allocation to health. Nonetheless, in its development plans and Vision 2030 the GRZ gives high recognition to the need for health systems strengthening.

4.4.2 To what extent has UNFPA supported implementing partners and beneficiaries in developing capacities and establishing mechanisms to ensure ownership and durability of effects?

Summary

Sustainability of results is seen in the training and deployment of SMAGs and midwives in the UNFPA-supported districts and provinces, and support for facility medical equipment, contributing to improved indicators for maternal deaths and fistula and to greater community acceptance of ANC attendance and facility delivery. These results should have long-lasting effects.

Training of CBDs has raised the accessibility and uptake of modern family planning, also likely to be a long-term result. However, it is unclear to what extent condoms are effectively promoted or taken up in conjunction with injectables and implants, and whether HIV incidence is declining in the programme areas.

Continued capacity building in implementing partners around data generation, dissemination and use should contribute to long-term results, particularly the introduction of geo-spatial training for sub-national in-depth analysis. Government ownership regarding population data is fully in place, and support is planned through a university-based centre of excellence to institutionalise geo-spatial training and data warehousing.

A significant contribution of UNFPA leading to sustainable effects is the training of Safe Motherhood Action Groups (SMAGs). Where they are deployed in the community, the proportion of women attending for early antenatal care and the full number of recommended ANC visits, as well as facility delivery, has increased, maternal deaths are declining to some extent, and new fistula cases are reduced (KIIs with provincial and district health staff and facility staff, FGIs with SMAGs and

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beneficiaries, document review at facility and district level). The SMAGs tend to have low attrition rates, thus training them has been a strategic long-term investment. Community attitudes among both women and men have changed in favour of facility attendance (KI interviews, FGIs with SMAGs, community based distributors/CBDs, beneficiaries, document review and facility reports) reducing the delay in seeking medical assistance around delivery. This is backed by increased availability of basic EmONC through trained and deployed midwives. Provided these cadres have low attrition rates, current and continued training should lead to sustainable benefits.

Regarding SRHR, HIV and GBV, sensitising and changing attitudes among traditional custodians of culture, chiefs and headmen and religious leaders, and of women, men and young people in the community, on adolescents' needs to access SRHR information and services, the dangers of child marriage, and the need for full antenatal care and facility delivery, should also lead to sustainable results. The CBDs have also facilitated easier access to contraception in the community and, with training on long-term reversible contraceptives, reduce pressures on the health facility staff. It was not possible to assess the uptake of condoms as providing triple protection (FP, and STI/ HIV prevention) in addition to LARCs, however, despite attempts to explore this during fieldwork.

Sustainability of results regarding population data should be apparent in that government IPs fully own the core activities, such as the demographic and health surveys and the census, and there has been further building of government capacity (KI interviews, document review). UNFPA technical and financial support complements existing government programmes and activities that are integrated in plans and have a budget. The 8CP has clearly added value in that the pace of implementation of activities would be negatively affected without UNFPA support. KI interviews indicated that the IPs are aware of the decrease in UNFPA core resources and suggested that other funding agencies be brought on board to support the population dynamics component further.

IPs (KI interviews, document review) particularly appreciated sub-national in-depth analysis and want continuation with regards the 2020 census data. There are concerns that without UNFPA support this activity might be dropped, although capacity building of IP staff through UNFPA technical and financial support contributes to sustainability of results.

The National Spatial Data Infrastructure activities are integrated in government plans and budget and appear sustainable, although a tentative finding is that risks could arise (KI interviews) in updating settlement models and satellite imagery without UNFPA support, as these depend on an expensive annual licence subscription. To ensure sustainability of GIS skills and capacity in the country, UNFPA technical and financial support through the GRID3 programme will establish a GIS Centre of Excellence at the University of Zambia to provide short training courses with integrated GIS content in the main curricular and will conduct spatial research (KI interviews with IPs, partners and CO). The centre will be equipped with computers and GIS software and will serve as a data warehouse.

4.5: Coordination

4.5.1 To what extent has the UNFPA Country Office contributed to the functioning and consolidation of UNCT coordination and to delivering as one, including with regards areas of potential overlap while maintaining its mandate?

Summary

UNFPA is a highly valued partner at UNCT level and in extensive joint programming across the thematic areas. During the 8CP the CO has contributed effectively to the functioning and consolidation of UNCT coordination and to DaO, including with regards potential areas of overlap while maintaining its mandate.

An independent resident coordinator (RC)[149] coordinates the UNCT, with a rotational chair for monthly meetings and a full-time UN Coordination Specialist in post to support DaO functioning. KI interviews confirmed that UNFPA is an active member of the UNCT and participates in the cross-cutting Programme Advisory Group, Operations Management Team, and UN Communications and M&E Groups. KI interviews confirmed strong linkages and synergies between partners, with UNCT members describing UNFPA as highly pro-active and reliable in the areas of its mandate (KI interviews).

Zambia volunteered as a DaO country in 2011, and became a fully-fledged DaO country in 2015 with the launch of the Zambia-UN Sustainable Development Partnership Framework 2016-2021 (see below). KI interviews and document review

[149] Total delinkage from UNDP was in place from January 2019

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indicate that the Partnership Framework has greatly strengthened synergies between agencies in planning, sharing information, co-financing and working together on joint or complementary programmes, compared with the previous UN Development Assistance Framework, UNDAF. From 2016, the integrated approach has involved agencies participating in results groups within which theme groups focus on particular areas of development. UNFPA participation in these mechanisms includes, in particular, those relating to strengthening SRH service provision and demand creation, SRH commodities, data generation, analysis and use, and programming for adolescents and youth.

Among other functions, UNFPA co-chairs the Human Development Results Group with WHO and WFP, that includes all aspects of SRHR, co-chairs the Data Theme Group, and actively participates in the Communications and M&E Groups. The UN structures link directly with multi-sectoral committees and technical working groups of the 7NDP, led by GRZ and key partners. Thus GRZ coordination structures are in place to which the UN coordination structures align, and these are reported to be working well in the areas of the UNFPA mandate (KI interviews). UNFPA (KI interviews, document review) was described as an effective and reliable coordinator and contributor at all levels. The UNCT, with UNFPA participation, was redesigning DaO structures under a new Resident Coordinator in mid-2019 to promote greater efficiency and impact.

With regards potential for overlap of mandates, this was not reported as a significant challenge (KI interviews). On the contrary, UN KI and CO interviews stressed synergies and mutual agreement on the division of labour for shared intended results, with collaboration described as particularly strong around youth. Mid-Term Review (MTR) of the Partnership Framework found fairly high compliance among partners to DaO. UNFPA staff performance appraisals include DaO.

Challenges in full DaO for all agencies (KI interviews) include achieving balance between vertical accountability to their headquarters and commitment to DaO, the need to adopt the UN logo yet also to ensure the visibility of their own agency, and possible issues of competition for funding, although donors increasingly favour joint funding. Progress is reportedly being made (KI interviews) towards full alignment, and with significantly increased GRZ engagement since 2018.

One strategic issue that arose (KI interviews) relates to how DaO should be interpreted with respect to achievement of results and sustainability. DaO may be measured as the extent to which UN agencies contribute to the Partnership Framework both financially and technically, and with regards M&E and reporting and other functions, how regularly they meet and contribute to results and theme groups, share information and collaborate in joint programmes according to their mandates and the UN division of labour. Another measure is how effective and efficient is the continuum of care from a human-centred perspective, with each agency contributing from its comparative advantage to respond to country needs together from the start. From this perspective, UN interviews cited examples of well-coordinated and streamlined approaches to joint programmes involving UNFPA, where each contributed according to its comparative advantage, noting that areas of potential overlap were openly discussed and the division of labour agreed from the start. Examples cited included: joint programming with a clear division of labour, especially between UNICEF and UNFPA regarding adolescents, e.g. on child marriage; with multiple partners in H6 and within the RMNCAH&N programming; between UNFPA and UNAIDS leading on sexual transmission of HIV; and the integrated response to the humanitarian situation in Nchelenge District in Luapula with extensive UNFPA inputs.

During the 8CP, UNFPA has been actively engaged in RMNCAH&N within the global H4+ partnership, now the H6[150] partnership, which UNFPA now chairs. The partnership brings together the comparative advantage of these agencies to provide technical support to government programmes, to convene and promote coordinated action, to advocate for evidence-informed programmes and policies and for targeted resource mobilisation. In Zambia the partnership has contributed to several joint programmes including the Millennium Development Goal Initiative (MDGi) and other initiatives described below. The H6 has developed a 2019-2020 action plan that has key strategic interventions based on the Global H6 results framework (KI and CO interview). The H4+ programme operated from 2011 to 2016 in Zambia and nine other countries to boost RMNCAH&N,[151] with lessons learned for continued programming and the aim of documenting and sharing lessons learned to boost south to south learning (KI interviews and document review).

UNFPA provided technical and financial support for health systems strengthening in the Ministry of Health through the planned five-year RMNCAH&N programme, jointly with UNICEF, in all districts of Western and Central Provinces. This included the development in 2018 of the RMNCAH&N Communications and Advocacy Strategy. There was a clear division of labour for RMNCAH&N with UNFPA supporting reproductive, maternal and adolescent health and related health systems strengthening (see EQ2), and UNICEF supporting child health, demand creation, social accountability and nutrition (KI

[150] UNAIDS, UNFPA, UNICEF, UN Women, WHO and World Bank Group
[151] UNFPA Evaluation Office (2017) End Evaluation of H4+ Joint Programme of Canada and Sweden

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interviews and document review). The programme began in the fourth quarter of 2017 but in mid-2018 DfID withdrew funding (KI interviews) because of judiciary concerns about financial management within GRZ (though not in MoH). This unforeseen circumstance led to the dropping of most activities, with contingency plans to sustain some support while developing a new phase of the programme. DfID will continue to provide funding for this through UNFPA who will process invoices through direct payment modalities to vendors, and without direct payments to GRZ. Consultants have been engaged to address a new phase of RMNCAH&N that is less ambitious and more streamlined and manageable (KI interviews, document review), and to ensure a responsible exit programme and transition. The new focus will be mainly on family planning and adolescent SRHR, and it is anticipated to begin in the fourth quarter of 2019 in five health facilities in each district (16 in Western and 12 in Central province). KI interviews commended UNFPA on a responsible and competent response to the suspension of funding, despite the inevitable disruption caused.

The six-year Millennium Development Goals Initiative (MDGi) was a GRZ programme implemented under the joint management of the European Union (EU) and UNICEF in collaboration with UNFPA from 2013-2019 to accelerate progress towards reducing maternal, neonatal and child morbidity and mortality. Partners included Planned Parenthood Association of Zambia, Marie Stopes International, Akros and CIRDZ.[152] Beneficiaries were mothers, newborns, children and adolescents in six rural and urban districts in Lusaka Province and five in the Copperbelt. Document review indicated that the programme had five expected results,[153] to which UNFPA contributed primarily through strengthening EmONC through health provider training, maternal and neonatal death review, training of community based volunteers (CBVs) including SMAGs, CBDs and youth peer educators, comprehensive sexuality education (CSE) for out of school youth, and supporting ASRHR services. UNFPA also supported condomize campaigns and helped strengthen supply chain management of male and female condoms among other areas of engagement. All these inputs were fully in line with the intended results. The division of roles and responsibilities was said (KI interviews) to be complex, however, and not always clear. Initially, WHO was also involved, but pulled out prior to implementation.

Training for CBVs and health care providers significantly exceeded targets,[154] with CBVs strengthening community capacity to deliver RMNCAH&N interventions in the target districts. One key outcome result was reduction in pregnancies in girls under 18 in both provinces according to MoH, HMIS 2018. UNFPA support for both the increase in ASRHR services from 2015 and the introduction of CSE in early 2017 are likely to have contributed to this result. Results targets were also exceeded for the reduction of maternal mortality in the supported facilities from the baseline of 15 per cent (target 10 per cent and status at programme end reported as 0 per cent).[155] Many lessons can be learned from this programme, including good practice and challenges, and the upcoming ex-post evaluation (October 2019 to March 2010) will elaborate these further in exploring sustainability and scale up of the approach. One key recommendation for the way forward is to strengthen the focus on adolescent health and SRHR, which is a strategic area of engagement of UNFPA in the 7 and 8CPs. Despite challenges in the joint programme, UNFPA should remain fully engaged.

Overall, the 8CP contributions to joint programming have been extensive, well focused and highly appreciated by partner organisations and beneficiaries (document review, KI interviews). Clarity of roles must be assured early on, with joint planning and design from the start, including intended beneficiaries to ensure a human-centred approach.

4.5.2 How and to what extent are the UNFPA priorities and mandate reflected in the Zambia-UN Sustainable Development Partnership Framework 2016-2021 pillars, indicators and targets?

Summary

The UNFPA priorities and mandate are well reflected in the Zambia-UN Sustainable Development Partnership Framework 2016-2021 within two of the three pillars (Pillar 1 on inclusive social development, and Pillar 3 on governance and participation). Pillar 2, on economic development, also includes three vulnerable populations of concern to UNFPA, women, youth and people with disabilities. The UNFPA 8CP output indicators and targets align with the UNFPA corporate strategy but contribute in the areas of its mandate to synergistic outcomes of the Partnership Framework.

[152] Centre for Infectious Disease Research, Zambia

[153] These were improved nutrition, increased availability of a continuum of quality maternal, neonatal and child health services, increased knowledge and demand for these services, improved coverage and accessibility of adolescent and youth friendly services, and strengthened capacity of the Ministry of Health and other stakeholders at national, provincial and district level.

[154] GRZ-EU-UN Millennium Development Goal Initiative Key Results and Lesson, presentation to final Steering Committee Meeting 13 August 2019

[155] Ibid.

During the 7CP the CO was actively involved in the development of the Zambia-UN Sustainable Development Partnership Framework (UNSDPF) 2016-2021, including for M&E, and setting indicators and targets to which all UN partners commit to contribute. The UNSDPF has three pillars, a common budgetary framework (see Chapter 3), and an M&E calendar.

The UNFPA priorities and mandate are well reflected in the partnership framework within two of the three pillars. Pillar 1 on inclusive social development has two outcome areas, 1.1 being that by 2021 government and partners deliver equitable, inclusive, quality and integrated social services. This includes the UNFPA-related results area indicator on the proportion of births attended by skilled health personnel. Outcome 1.2, that by 2021 marginalized and vulnerable populations in Zambia demand and utilise quality and integrated social services, includes the UNFPA-related result area indicators on the adolescent birth rate, modern contraceptive prevalence in women of reproductive age, and the percentage of women aged 25-49 who were married before the age of 18. The outcome also includes a focus on HIV testing in males and females aged 15-24, integral to the UNFPA focus on integrated SRHR, HIV and GBV services, and on SRHR services being adolescent and youth friendly. The indicators are not 100 per cent the same as those of UNFPA (e.g. the UNFPA indicator for adolescent HIV testing is for adolescents 15-19), as the UNFPA indicators are drawn from the UNFPA corporate strategy.

Pillar 2, on environmentally sustainable and inclusive economic development, does not reflect UNFPA priority area results except, indirectly, insofar as the needs of women, youth and people with disabilities, focal UNFPA populations, are reflected with regards economic empowerment.

Pillar 3, on governance and participation, has four outcomes, the first of which is that by 2021 the national statistical system generates and disseminates timely disaggregated data for evidence-based national development. This includes the UNFPA-related results indicators on the proportion of planned surveys conducted and results released on schedule, the number of government ministries with functional management information systems, and the percentage of users reporting satisfaction with the quality and timeliness of data provided by the National Central Statistics Office System. Outcome indicator 3.2 is also relevant to UNFPA, the percentage of annual government budget/expenditure to main social sectors, which includes health. With regards Outcome 3.3, UNFPA contributes to the Gender Inequality Index. UNFPA does not contribute directly to any of the indicators under Outcome 3.4 beyond the support for survivors of GBV that might contribute in a limited way to increased percentage of GBV cases adjudicated. EQ2 elaborates further.

The 8CP and Partnership outcomes are highly synergistic and, although outputs are all aligned to the outcomes, they vary by agency regarding indicators and targets. UNFPA outputs and targets primarily relate to the UNFPA corporate strategy. UNFPA indicators and targets were set for 2020 but will be amended to 2021 in line with the Partnership and 7NDP.

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Chapter 5: Conclusions

The conclusions logically flow from the findings presented in the previous chapter. These conclusions are presented at strategic level (such as relevance, responsiveness, efficiency, and coordination and sustainability) and programme level.

5.1.1 Strategic Level

Conclusion 1: The scale of UNFPA programming and staff complement, including sub-national offices, the extent of poverty and income, gender and geographical inequality, poor SRHR indicators across the youthful population structure and high population growth rate, are reflective of a 'big' country programme, which the theory of change does not fully reflect.

Origin: Evaluation questions 1 and 2; **Evaluation criteria:** Relevance, effectiveness

Associated recommendation: 1

The 8CP has been strongly and effectively aligned to both the international and the national agenda for SRHR, including a special focus on adolescents and youth, particularly girls, and supporting GRZ regarding the generation, analysis and dissemination for use of population data. In particular, the CO has been catalytic in supporting the development and institutionalisation of integrated SRHR, HIV and gender based violence services in multiple ways, and has demonstrated gender responsiveness, and attention to human rights including an emerging focus on people with disabilities. The 8CP has continued to employ all modes of engagement and is on track or has exceeded most of its output targets that are logically linked to intended outcomes. The theory of change underlying the results chain appears fairly robust but can be strengthened with respect to outputs, interventions to address them, and with regards indicators.

The overall conclusion is that the CP strategy has been highly appropriate with regards international goals and national and sub-national programming, including for an emerging humanitarian emergency. Limitations noted include the absence of a population dynamics specialist during the 8CP, and relatively low focus on key populations of sex workers and men who have sex with men. However, the overall scale of programming is high, with a large and expanding main country office and sub-office staffing complement to address the extensive unmet needs in SRHR, for adolescents and youth and to assure strengthened data for development. The country continues to have high population growth with a youthful population structure and severe inequalities. The scale of development support required is likely to increase given stagnation in socio-economic development of the past few years.

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Conclusion 2: Although Zambia achieved lower middle income country (LMIC) status, severe inequalities and widespread poverty remain high with implications for the appropriate modes of engagement of UNFPA.

Origin: Evaluation question(s) 1, 2, 4; **Evaluation criteria:** relevance, effectiveness and sustainability

Associated recommendation: 2

Although Zambia achieved sufficient economic growth to be designated an LMIC, wide inequalities and poverty remain major concerns. UNFPA is in discussion with GRZ concerning increased domestic funding, particularly for reproductive health commodity procurement for which UNFPA continues to contribute substantially, and the CO is alert to the need to continue capacity development for integrated SRHR, HIV and GBV, to increase service demand further and to strengthen data for development (particularly regarding the upcoming 2020 census). At present, caution is needed in terms of reducing direct service delivery to avoid the risk of declining quality, and all modes of engagement remain relevant.

Conclusion 3: Monitoring and evaluation plans and systems for quality assurance are in place but the implementation of M&E for quality assurance needs to be strengthened particularly for SRHR and the adolescent and youth thematic areas.

Origin: Evaluation question 3; **Evaluation criterion:** Efficiency

Associated recommendation: 3

Some implementing partners, including in government, do not have dedicated monitoring and evaluation specialists and M&E is a shared task. The capacity for M&E using results based management is therefore often insufficient, despite sessions in annual meetings, and continuous development is needed (particularly where staff attrition is high). Within the CO, although quality assurance visits to implementing partners are intended to be undertaken quarterly, high pressures of work mean that this frequency of visits is not achieved, and consistency in report assessment between IP managers in the CO is not assured despite formal staff training. Provincial and district health officers only undertake quality assurance visits when funded by UNFPA to do so.

At facility level, therefore, despite continued staff training, there is insufficient quality assurance of sustained outcomes of training, that trained nurses and midwives are able to and consistently apply their training, and that at model sites for integrated services for SRHR/HIV/GBV support that staff have fully taken on board a client-centred approach.

Conclusion 4: The 8CP has demonstrated strong commitment to UNCT coordination and to delivering as one, with its mandate and priorities well reflected in the UN Joint Strategic Partnership Framework.

Origin: Evaluation questions 1, 2, 5; **Evaluation criteria:** relevance, effectiveness, coordination

Associated recommendation: 4

In the 8CP UNFPA CO has demonstrated high commitment to UNCT coordination and to delivering as one at all levels, with several joint programmes and projects. These have mostly demonstrated a clear division of labour and complementarity according to each agency's comparative advantage in delivering a client-centred continuum of care. Experience has shown that joint planning and clarification of roles from the start promote effective programme implementation.

Conclusion 5: Late disbursement of funds and limited time frames for expenditure are challenging the implementation of activities by many implementing partners across the thematic areas, particularly in the first quarter.

Origin: Evaluation questions 2 and 3; **Evaluation criteria:** Effectiveness and efficiency

Associated recommendation: 5

Several reasons have been raised to explain late disbursement of funds, including late submission of acceptable reports, delays in CO approval, and changes in the on-line systems in the CO that incurred teething problems for implementing partner to incorporate fully, and backlogs and delays within the CO in processing payments. However, despite the challenges of adapting to new systems, with sufficient training compliance is improving.

In specific, limited situations, where supplementary funding from GRZ is not guaranteed (e.g. for provincial planning or review meetings) annual allocations for designated activities for implementation throughout the year would avoid risk of delays and increase efficiency and effectiveness of implementation.

5.2.1 Programme Level: Sexual and Reproductive Health

Conclusion 6: The 8CP has made substantial contributions to the H6 partnership, RMNCAH&N policy and programming, health provider capacity development and, especially, to integrated SRHR, HIV and GBV service provision, contributing to some improved outcome indicators.

Origin: Evaluation questions 2, 4; **Evaluation criteria:** effectiveness, sustainability

Associated recommendation: 6

In the 8CP UNFPA has continued to provide substantial technical and financial support to areas within its mandate of RMNCAH&N though several joint programmes. In particular, the integrated SRHR, HIV and GBV programming has been catalytic in promoting national ownership of and commitment to an integrated service approach. Implementation in the selected sites is stronger regarding SRHR and HIV than the full response required regarding human rights around GBV, but

gender sensitivity, basic awareness of the needs and rights of people with disabilities, and strong endorsement of the rights of adolescents to SRHR information and services are apparent. Quality assurance needs to improve, including with regards how far clients receive full integrated services from one staff member, and how far guidelines are being followed.

Conclusion 7: Training Safe Motherhood Action Groups (SMAGs) and community based distributors (CBDs), female and male, has been an effective and efficient strategy to raise community awareness, change attitudes among men and women, and increase uptake of SRHR and HIV services, although significant barriers to uptake of contraception remain as well as concerns regarding the supply chain.

Origin: Evaluation questions 2, 3 and 4; **Evaluation criteria:** Effectiveness, efficiency and sustainability of results

Associated recommendation: 7

Community attitudes to antenatal attendance and facility-based delivery have significantly improved with long-term SMAG activity and also the engagement of the custodians of tradition. Involving men to change community attitudes is of particular importance regarding safe motherhood, to strengthen family planning uptake, to encourage HIV prevention, testing and treatment, and to reduce GBV. SMAGs are highly valued in the communities but could be more efficient if they have adequate supplies of e.g. bicycles, torches, boots and umbrellas to cope in rainy seasons, and UNFPA is in process of responding to this need. They also seek refresher courses to keep up to date. A number of SMAGs have also been trained as CBDs, which appears an appropriate and efficient approach. CBDs are also highly valued and their presence greatly facilitates access to FP, particularly with training in injectables as well as short term methods. Retention rates of SMAGs and CBDs appears generally to be high, making their training and deployment a cost-effective approach. More areas need to be covered by CBDs and stock outs of particular contraceptive options are of concern (although other options may be availed).

Conclusion 8: Key populations of sex workers and men who have sex with men and wider LGBTI populations face deeply challenging policy and social environments, but UNFPA has had limited engagement beyond policy level and in one joint programme (2gether 4SRH).

Origin: Evaluation question 2; **Evaluation criteria:** effectiveness

Associated recommendation: 8

A deeply challenging legal and social environment exists for key populations of LGBTI, sex workers and people who inject drugs,[156] impeding programming to address their SRH, HIV, GBV and wider human rights. Negative attitudes prevail among many health providers. Apart from the fundamental need to assure their basic human rights as vulnerable and marginalized people, addressing their needs for HIV prevention is essential if Zambia is to reach the 2030 goal of no new HIV infections and to end the AIDS epidemic. Addressing their needs for HIV prevention is one of the five pillars of the Zambia HIV Prevention Road Map to which UNFPA contributed, and is reflected in the National AIDS Strategic Framework. During the 8CP UNFPA has not, however, been extensively involved with key populations of MSM, LGBTI or sex workers in Zambia despite these populations falling within its mandate.

Many development partners are engaged and funded to support policy and programme engagement with these populations, including advocacy and awareness raising around their needs and rights. The knowledge base on these populations is weak, however, and needs strengthening to increase and ensure appropriate geographical coverage, for advocacy purposes and to help streamline programming effectively. Active engagement of the beneficiaries is essential, although networks remain weak, and well-proven international guidelines on effective programming are available.

Conclusion 9: People with disabilities remain under-served in the full range of integrated SRHR services and the UN Joint Disability Inclusion Project is a timely intervention.

[156] Support for PWD falls outside the mandate of UNFPA in the UNAIDS division of labour

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Origin: Evaluation question 2; **Evaluation criteria:** effectiveness

Associated recommendation: 9

Stigmatising attitudes to people living with disabilities, and negative beliefs about the causes of disability, remain widespread, with a common view that people with disabilities do not need or have the right to access SRHR services. Raising their access to services and to realise their human rights in all spheres is important, including their needs and rights to integrated SRHR, HIV and GBV services. In addition, people with different disabilities may not have access to the information they need, let alone service access. The Disability Inclusion Project is a promising step.

Conclusion 10: During the 8CP UNFPA has continued to address fistula repair, including through costly camps, and the community health volunteers are both identifying women with fistula and helping to prevent fistula by increasing antenatal visits and facility delivery.

Origin: Evaluation question 2; **Evaluation criteria:** effectiveness and sustainability

Associated recommendation: 10

The 8CP has stepped up fistula identification and repair, with fistula camps run by obstetricians with specific fistula training. The holding of fistula camps to undertake repairs, however, is not sustainable; training surgeons for provision of services in different provinces is more cost effective. The incoming of the international Fistula Foundation provides an opportunity for UNFPA to leverage an effective partnership utilising their respective areas of comparative advantage. The establishment of a fistula ward at Mansa General Hospital in Luapula Province is positive, and a road map on fistula is nearing completion.

5.2.2 Programme Level: Adolescents and Youth

Conclusion 11: The 8CP has strengthened policies, strategies and programmes addressing the integrated SRHR needs, knowledge, demands, access to and service provision for young people, particularly adolescent girls and young women, but greater resource allocation is needed to intensify this focus in the coming CP.

Origin: Evaluation questions 1, 2 and 4; **Evaluation criteria:** Relevance, effectiveness, sustainability

Associated recommendation: 11

The 8CP has continued to address young people through all modes of engagement, contributing to policy and strategy development and addressing laws and attitudes that are barriers to adolescent SRHR service provision, in and out-of-school comprehensive sexuality education, child marriage, and training peer educators and mentors to build knowledge and demand for SRHR services. Linkages between the health and education sectors are being strengthened to promote direct referrals. Safe spaces have been developed within existing health facilities, although these remain at a very basic level. It is not sustainable to provide the range of equipment and facilities that young people and peer educators would like. Overall, the interventions for young people are strategic, given their inadequate SRHR knowledge and uptake of contraception and other services, and the insufficiently enabling environment. Resource allocation for AY, however, has been low compared with that for wider SRHR given the importance of reaping the demographic dividend of a youthful population, and the impact of peer education is challenged by high attrition rates. Despite progress, SRHR indicators remain high (e.g. teen pregnancies, HIV, child marriage and GBV), and marginalized young people, including those with disabilities, need greater attention.

Conclusion 12: Partnerships for the child marriage programmes have yielded measurable results and this appears a strategic focus in the Zambian context to protect marginalised adolescent girls to stay in school and improve ASRHR.

Origin: Evaluation questions 1, 2 and 4; Evaluation **criteria:** Relevance, effectiveness, sustainability

Associated recommendation: 12

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The 8CP has addressed child marriage through strategic joint partnerships at national and district level with a multi-sectoral response. This has involved all modes of engagement ranging from legal and policy development to changing community and health provider attitudes, creating safe spaces for vulnerable adolescent girls, and empowering them and their male counterparts with knowledge, mentoring and socio-economic asset building for the most marginalised and at risk. The programmes have aimed to assist married girls to return to school, and in some cases to dissolve existing marriages.

Conclusion 13: Although the office structures around SRHR, AY and gender are linked, strengthening collaboration and synergies could be beneficial with regards communications between teams to achieve inter-linked results.

Origin: Evaluation questions 2 and 3; **Evaluation criterion:** effectiveness and efficiency

Associated Recommendation: 13

The specific programmes and projects addressing SRHR, AY and gender are logically linked, with overlapping activities and results areas, but they are managed within different teams within the CO (and also with the sub-offices). Two staff, an adolescent SRHR specialist who also works on HIV, and a UNV, are specifically dedicated to the component area of adolescents and youth, with 50 per cent staff time from a Junior Programme Officer, and other staff contributing to work with adolescents and youth through various programmes (e.g. on ending child marriage, or in RMNCAH&N). The focus on adolescents and youth is particularly critical in the UNFPA mandate in a country with a youthful population, high population growth, serious economic inequalities, and severe gender inequality and inequity.

5.2.3 Programme Level: Population Dynamics

Conclusion 14: Marked achievements have been made during the 8CP in the area of population dynamics; however, the implementing partners all noted with concern the absence of a population dynamics specialist.

Origin: Evaluation questions 2 and 3; **Evaluation criteria:** Effectiveness and efficiency

Associated Recommendation: 14

As the only UN partner addressing population dynamics, it is essential that UNFPA maintains a high level of assistance in this component area. A great deal has been achieved during the 8CP, as evidenced by interviews and documentation, but it does not appear optimal to have to share related population dynamics tasks among several different staff, despite the competence of the assistant representative as a qualified demographer. The imminent recruitment of a UN volunteer as a focal point is an important development to help ensure consistency of participation in meetings, technical and other processes, but there remains need to explore further the potential benefits of having on board a full population dynamics specialist. This is particularly so in light of the imminent census and to sustain and develop further sub-national analysis that has been a major contribution during the 8CP.

Conclusion 15: Modalities for the dissemination of sub-national in-depth analysis of key socio-economic and SRHR indicators have improved and are reaching planners and policy-makers at all levels for evidence-based decision-making and planning, with strong alignment to the SDGs, although some gaps in indicators remain.

Origin: Evaluation question 2; **Evaluation Criteria:** Effectiveness

Associated Recommendation: 15

The demographic dividend findings were used to inform the 7NDP, and the SDG goals were mainstreamed into the national plan. This was achieved with effective coordination between the UN and other partners with government, and indicators were developed that facilitate monitoring against the SDGs. With policy briefs disseminated to parliamentarians to inform policy debate, and to policy makers at different levels, information and evidence regarding SRHR were well shared.

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The use of geo-spatial map profiles in the dissemination of sub-national in-depth analysis of key socio-economic and SRHR indicators was appreciated at all levels to strengthen evidence-based decision-making and planning. This was a new development in the 8CP and needs to be developed further, and to include further indicators such as on disability.

Conclusion 16: Capacity building of implementing partners in data generation, utilisation and dissemination enhanced the integration of evidence-based analysis on population dynamics in development policies, plans and agendas, although the extent of continued application of training was not sufficiently assured.

Origin: Evaluation question 2; **Evaluation Criteria:** Effectiveness

Associated Recommendation: 16

The integration of evidence-based analysis on population dynamics in development plans such as the 7NDP is a clear indication of the development of IP capacity regarding disaggregated data generation, utilisation and, to some extent, dissemination. However, it is not clear whether the training is leading to sustained capacity development over time given that staff tend to be moved into different positions where their training may no longer be highly relevant. Closer monitoring of the results of skills training is required, particularly at provincial and district levels. All sub-national plans are linked to the 7NDP and their continued linkage with the next NDP needs to be assured.

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Chapter 6: Recommendations

The recommendations are linked to, and flow logically from the conclusions as shown by the cross-referencing. The level of priority is indicated and operational implications (i.e. human, financial or technical) are described. With regards to timelines, these actionable recommendations will largely inform 2020 annual planning, the extension of the 8CP in 2020 and the next programming cycle (9CP) in 2021.

6.1 Strategic level

Recommendation 1: The next CP should maintain and intensify the core focus and thematic areas of the 8CP with the expanded staff complement, with consideration of classifying the Zambia CO as a big country office, and ensuring that the theory of change fully reflects the interventions and outputs required to contribute to outcomes, with commensurate indicators.

Priority: High; **Target level:** CO and Headquarters

Based on conclusion: 1

Operational implications: There are no major operational implications for change in focus or allocation of resources given that the development priorities in Zambia are not anticipated to change significantly in the next few years, but changing the classification of the CO would entail further core funding. UNFPA will need to continue the successful resource mobilisation demonstrated within the 8CP. and to maintain its strong focus on adolescents and youth to help Zambia reap the demographic dividend of a youthful population.

Recommendation 2: UNFPA needs gradually to consider moving further towards the higher levels of engagement for an LMI country and reduce GRZ dependence on direct service delivery but, in the short term, should maintain all modes of delivery.

Priority: High; **Target level:** Country office

Based on conclusion: 2

Operational implications: The current and planned increase in CO typology and the skills base for all levels of engagement should ensure that the CO remains on track to deliver in the next CP. The recent recruitment of the Deputy Representative is significant, and the one critical gap is the frozen post for a population specialist (see the first recommendation under population dynamics). To avert the risk of reduced quality and coverage of services the CO should continue service delivery and remain alert and flexible to changes in the country's economic situation and levels of GRZ health funding and capacity in the next CP.

Recommendation 3: Quarterly programme monitoring visits and validation of data reported by IPs in GPS need to be strengthened, and provincial health officers need regular budgets to ensure that they can undertake sufficient quality assurance in the districts and health facilities.

Priority: High; **Target level:** Country office

Based on conclusion: 3

Operational implications: The operational implications are that increased time and financial expenditures will be needed for training and mentoring IPs and to achieve the intended quality assurance by provincial and district health officers and the CO.

Recommendation 4: UNFPA should maintain its proactive position regarding UNCT coordination and DaO and explore further opportunities for joint programming.

Priority: Medium; **Target level:** Country office

Based on conclusion: 4

Final

Operational implications: No specific operational implications arise for resource mobilisation, human resources or further technical requirements. Joint programming and fully aligned indicators should lead to greater efficiencies in programming and in monitoring and evaluation, and joint financial resource mobilisation is the preferred funding approach of international donors.

Recommendation 5: Further capacity needs to be built in both implementing partners and within the CO typology to ensure timely and acceptable reporting to facilitate resource disbursement, with the new reporting modalities introduced in the 8CP fully and efficiently operationalised; consideration is needed on how to resolve the situation where delays in implementation lead to return of funds.

Priority: Medium; **Target level:** Country office, ESARO, HQ

Based on conclusion: 5

Operational implications: The new systems should lead to increased efficiencies in reporting and financial disbursement once fully understood and operationalised, with no further operational or cost implications beyond the need for continued mentoring of implementing partners and the CO.

6.2. Programme Level: Sexual and Reproductive Health

Recommendation 6: UNFPA should continue to strengthen technical and financial support for integrated services in the areas of its mandate in RMNCAH&N, the follow up to the MDGi programme, and other programmes with proven results, and for health provider capacity development and sensitisation, working within the H6 partnership and joint programmes according to DaO.

Priority: High; **Target level:** Country office

Based on conclusion: 6

Operational implications: There are no new operational implications arising from this recommendation, beyond ensuring that sufficient human, technical and financial resources are made available to continue this core and strategic engagement.

Recommendation 7: UNFPA should continue to train SMAGs and CBDs for unsupported facilities in the provinces supported by UNFPA, including to address barriers to contraceptive uptake and to strengthen the supply chain further; and, depending on resources, UNFPA should consider widening the provinces and/or districts covered or intensifying programming within existing provinces and districts, as well as earmarking funds for refresher courses and further basic benefits.

Priority: High; **Target level:** Country office

Based on conclusion: 7

Operational implications: Training further community health volunteers and providing refresher courses and basic equipment have cost implications that appear justified given the commitment of these community volunteers and sustainability of results. The barriers to contraceptive uptake need to be better understood and addressed, as well as further strengthening of the supply chain, potentially with operational research to address gaps in information, south to south learning and intensified efforts to replicate approaches that have shown results.

Recommendation 8: The CO should step up its engagement with the LGBTI populations and sex workers to promote their knowledge, access to and uptake of integrated SRHR, HIV and GBV services, including support for size estimations and other essential data and to address the challenging political and social environment at all levels through sensitive advocacy.

Priority: High

Final

Target level: Country office

Based on conclusion: 8

Operational implications: More human and technical resources should be directed to engagement with these key populations, through funding from UBRAF, Global Fund and PEPFAR, and with leverage of further funds during the 9CP. As co-sponsor with UNAIDS to prevent sexual transmission of HIV, UNFPA should engage in effective joint programming with other active partners to address gaps in programming to date, despite the challenging legal and political environment, and contribute to sensitive advocacy for an enabling environment.

Recommendation 9: Depending on the results, UNFPA should consider the expansion and/or modification of the UN Joint Disability Inclusion Project in the existing and other provinces, with further sensitization of health facility staff, traditional leaders, and community health volunteers on the SRHR, HIV and GBV needs and rights of people with disabilities, and help to empower people with disabilities themselves to claim their rights.

Priority: Medium; **Target level:** Country office

Based on conclusion: 9

Operational implications: Expanding the focus on people with disabilities is likely to require the mobilisation of additional financial resources, and for the UNFPA office to engage in further joint programming with partners with expertise around disability and rehabilitation, and networks of people with disabilities, as this is not a core area of expertise within the CO.

Recommendation 10: UNFPA should contribute to finalising the road map for fistula repair and strengthen partnership with the Fistula Foundation to establish clear roles and responsibilities according to respective areas of comparative advantage in support of the Ministry of Health.

Priority: Medium; **Target level:** Country office
Based on conclusion: 10

Operational implications: Engaging with the Fistula Foundation is an opportunity for efficient joint support for fistula management that should be more cost effective, efficient and beneficial to women with fistula than the present, unsustainable mounting of fistula camps.

6.3 Programme Level: Adolescents and Youth

Recommendation 11: Integrated SRHR/HIV/GBV programming for young people, especially vulnerable and marginalised adolescent girls and young women, needs to be scaled up with increased budgets for stronger results for young women and men, building on the 8CP experience regarding benefits and limitations to adolescent spaces in health facilities and the relative benefits, limitations and sustainability of peer education.

Priority: High; **Target level:** Country Office and HQ

Based on conclusion: 11

Operational implications: Consideration should be given to providing some core funding for this thematic area given its importance and the scale and extensive needs of the youthful population in Zambia. Attention should be given to ensuring that approaches to AY SRHR are sustainable and achieving the intended results in a cost-effective manner.

Recommendation 12: Building on experience during the 8CP, UNFPA should intensify and expand the focus on child marriage in the next CP, building on the strategic partnerships and gains in current programming, and should plan and budget for south to south learning documentation of the modalities and partnerships that worked well.

Priority: High; **Target level:** Country office, ESARO and HQ

Final

Based on conclusion: 12

Operational implications: Strategic partnerships should continue with clearly delineated and complementary roles between stakeholders, and sufficient budget allocation. Resource mobilisation jointly with other key partners is underway and should be continued to scale the programme in the extension of this CP and into the next CP. Office capacity is already in place and relationships built with key partners to achieve this, and additional core funding should be considered.

Recommendation 13: Consideration should be given to increased integration of AY, SRHR and the gender focus within the CO, and whether to expand the dedicated staff complement for AY given the importance of addressing the considerable SRHR (and other) needs of this large population cohort.

Priority: Medium; **Target level:** Country office, ESARO and HQ

Based on conclusion: 13

Operational implications: Review of the relevant office team structures, communication channels and linkages could lead to greater synergies in managing the various programme areas relating to AY. This should be undertaken and lead to consideration of whether the dedicated staff complement should be expanded for this critical thematic area (which could have cost implications).

6.4 Programme Level: Population Dynamics

Recommendation 14: Monitor whether it is sufficient to have in post a UN volunteer, with CO staff support, or whether a population dynamics specialist should be recruited to optimise results in this critical area of the UNFPA mandate.

Priority: High; **Target level:** Country Office, ESARO and Headquarters

Based on conclusion: 14

Operational implications: If justified, this post should be unfrozen and resources mobilised to recruit a full population dynamics specialist, particularly given the upcoming census and the need to continue and intensify sub-national data capture, analysis and use for evidence-informed policy, planning and programming.

Recommendation 15: UNFPA should promote close collaboration between all stakeholders and government to ensure the continued and strengthened linkages of the next national development plan with the SDGs, including support to strengthen user-friendly formats to disseminate in-depth analysis of population dynamics, and with further indicators including regarding people with disabilities.

Priority: High; **Target level:** Country Office

Based on conclusion: 15

Operational implications: Promotion of close collaboration for the next national development plan and continued development of user-friendly formats may have cost and human resource implications. High level engagement will be needed, as well technical capacity to design further materials for effective dissemination of data to influence decision-making and planning, and to include further indicators.

Recommendation 16: UNFPA should continue building the capacity of implementing partners in research, in-depth data analysis, population projections, small area estimation, policy analysis, and geo-spatial data analysis at nation and sub-national levels, and needs to monitor the application of skills gained from training over time.

Priority: Medium; **Target level:** Country Office

Based on conclusion: 16

Final

Operational implications: The capacity building of IPs and partners should be continued and sustained with adequate provision of technical support and the mobilisation of financial resources. Key areas for further capacity development include all the above areas to enhance the utilisation of data on population dynamics in evidence-based decision-making and development planning.

Lessons Learned

Strategic level

By supporting strategic partnerships within the UN system and with government and other stakeholders, and providing financial and technical support to the Ministry of National Development Planning, the UNFPA CO successfully contributed to the domestication of SDGs into the 7NDP, resulting in the National SDG Coordination and Implementation Framework against which to monitor progress and sustain close alignment in national and sub-national development planning.

Transition to increased domestic funding and reduction of service delivery as a mode of engagement will be challenging with the level of GRZ financial resources and capacity, despite the LMIC designation, given the extent of prevailing inequalities in Zambia and stagnation of economic growth in recent years.

The delivering as one focus is progressing well and achieving greater financial and technical synergies at national and programming levels, particularly when joint initiation of programme design and planning are undertaken from the start.

Introducing more streamlined monitoring and reporting tools to strengthen efficiencies has been appropriate, but the extent to which both UNFPA staff and implementing partners need capacity development to use them effectively should not be underestimated.

SRHR

The integrated SRHR, HIV and GBV focus is relevant, efficient and appreciated, highly unlikely to have emerged without UNFPA leadership, and scaling up requires sufficient quality assurance regarding fidelity to key components.

Mainstreaming of gender, human rights and disability are apparent in the 8CP and could benefit from utilising a clear rights based framework to enhance the focus, with stronger attention to the rights of particularly vulnerable populations.

Adolescents and youth

Creating a thematic area for the integrated SRHR response for young people is well justified given the young population structure and socio-economic vulnerability of young people, especially girls within a patriarchal society, and requires sufficient financial allocations and synergistic integration with the wider SRHR and gender focus within the CO.

Population dynamics

Given that no other agency contributes to population dynamics, the contribution of UNFPA to strengthen capacity for generation, dissemination and utilisation of population data at all levels and to provide high level technical and financial support remains a high priority.

The sub-national analysis and production of sub-national profiles, including sex and age disaggregated data at province, district, constituency and ward levels for integration of population dynamics, has been instrumental in increasing the dissemination and utilisation of evidence-based data in development plans and programming at all levels, as well as the identification of vulnerable populations and most needy geographical areas.

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ANNEXES

Annex 1: Terms of Reference

Terms of Reference

GRZ/UNFPA 8TH COUNTRY PROGRAMME 2016 - 2020

COUNTRY PROGRAMME EVALUATION

ZAMBIA

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Acronyms

8CP	8th Country Programme
CO	Country Office
CPE	Country Programme Evaluation
DSA	Daily subsistence allowance
EO	Evaluation Office
EQA	Evaluation Quality Assessment
ERG	Evaluation Reference Group
ESARO	East and Southern Africa Regional Office
GRZ	Government of Zambia
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
M&E	Monitoring and Evaluation
RO	Regional Office
SDGs	Sustainable Development Goals
ToC	Theory of Change
ToR	Terms of Reference
UN	United Nations
UNCT	United Nations Country Team
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNSDPF	United Nations Sustainable Development Partnership Framework

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1. Introduction

The eighth Country Programme (2016-2020) of United Nations Population Fund (UNFPA) Zambia Country Office (CO) support to the Government of Zambia (GRZ) responds to national priorities as articulated in the Seventh National Development Plan and the United Nations Sustainable Development Partnership Framework (UNSDPF). The GRZ and UN agreed to collaborate on achieving eight Partnership Framework outcomes under three broad results pillars: (i) Inclusive Social Development; (ii) Environmentally Sustainable and Inclusive Economic Development and (iii) Governance and Participation. UNFPA Zambia contributes to result pillars (i) and (iii). As part of the UN reform agenda, the Country Programme (CP) is implemented within the framework of Delivering-as-One. According to the UNFPA Strategic Plan 2018-2021 business model, Zambia falls in the red quadrant as a low-income country and applies five modes of engagement at the national and sub-county levels, namely: (a) Advocacy and policy dialogue; (b) capacity development; (c) knowledge management; and (d) partnership and coordination and; (e) service delivery.

The 2019 UNFPA Evaluation Policy requires Country Programmes to be evaluated at least once every two cycles and this policy will guide the evaluation process. In addition, the ten general, the United Nations Evaluation Group (UNEG) principles as well as the four institutional norms (see Annex 1) will be upheld and reflected in the management and governance of the evaluation. The Zambia Country Programme Evaluation (CPE) will document key achievements against set objectives as well as identify opportunities of operationalizing Zambia's Vision 2030 of becoming a "*prosperous middle-income country by 2030*" and inform the next country programme. The evaluation will demonstrate accountability to stakeholders on performance in achieving development results, value for money on invested resources, support evidence-based decision-making and contribute important lessons learned on how to further improve programming.

The evaluation will be conducted by a team of independent evaluators and will be managed by the UNFPA Zambia CO, with support provided by the East and Southern Africa (ESA) Regional Monitoring and Evaluation (M&E) advisor in the various stages of the evaluation process. The primary users of the evaluation results are the UNFPA Executive Board, UNFPA Zambia Country Office, the Government of Zambia, Cooperating Partners and the Implementing Partners. Evaluation findings will be disseminated to these audiences as appropriate including digital platforms such as social media and the country office website.

2. Country Context

The Republic of Zambia comprises 10 provinces and 105 districts. The 2018 population is projected at 16.4 million, with young people aged 10-24 years representing 34.4 per cent and women aged 15-49 years representing 51 per cent of the population. With an annual growth rate of 2.8 per cent and a 2013 total fertility rate of 5.3, the population is projected to reach 49 million by 2050.

Zambia is lower-middle-income country; its gross domestic product has averaged about 7 per cent for the past five years. However, a 2015 poverty report estimates 60 per cent of Zambians live below the poverty line, with extreme poverty levels of 42 per cent in rural areas and over 60 per cent for female-headed households. Zambia has a 2014 Gini coefficient of 0.65, illustrating high levels of inequality.

The maternal mortality ratio is still high, despite a decline from 591 deaths per 100,000 live births in 2007 to 398 per 100,000 live births in 2013. Though skilled birth attendance increased, from 47 per cent to 64 per cent, and institutional delivery increased from 48 per cent to 67 per cent over that period, both indices remain below national targets of 80 per cent. Despite improvement in the modern contraceptive prevalence rate, from 33 per cent in 2007 to 45 per cent in 2013, unmet need for family planning remains significant, at 21 per cent. Complications during pregnancy account for 60 per cent of maternal deaths, with Human Immunodeficiency Virus (HIV)-related maternal deaths accounting for 15.4 per cent. Health system performance reveals an unequitable distribution of skilled human resources for health, weak capacities for emergency obstetric care and stock-outs of reproductive health commodities in rural and underserved areas. Poorly resourced community support systems and limited male involvement also contribute to inequitable access and utilization of sexual reproductive health information and services.

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Despite a slight decline since 2013, HIV prevalence remains high, at 11.63 per cent (8.9 per cent in male and 14.5 per cent in female populations). Comprehensive knowledge of HIV is low (42 per cent among women and 49 per cent among men aged 15-49), as is condom use (29.7 per cent among women and 27.4 per cent among men aged 15-49 years). These are a result of policy and programme barriers that limit equitable access to information and services in rural and underserved areas. This is important, as most HIV infections in the country are sexually transmitted or associated with pregnancy, childbirth or breastfeeding. Drivers of HIV transmission equally lead to sexually transmitted infections and unintended pregnancies, and include high levels of transactional sex, multiple sexual partners and sexual gender-based violence (17 per cent among women and girls aged 15-49 years).

Limited coverage of rights-based comprehensive sexuality education for in-school and out-of-school youth, amid strong social norms and cultural practices, contributes to high levels of teenage pregnancy (29 per cent), which accounts for 58 per cent of school dropouts. Despite implementation of a school re-entry programme for pregnant girls, less than half return after delivery. Some 45 per cent of girls aged 25-49 years were married by age 18 and 65 per cent by age 20. In-depth analysis of the 2010 census and the 2013-2014 demographic and health survey indicates that the girls most vulnerable to teenage pregnancy and child marriage have low levels of education and belong to households in the lowest wealth quintile.

On average, about 113,000 households in Zambia are adversely affected by floods annually, cutting them off from road networks and health facilities, thereby limiting equitable access to integrated HIV, gender-based violence and sexual reproductive health information and services. Annual humanitarian preparedness planning and pre-positioning of reproductive health and dignity kits continue to play a critical role in saving the lives of vulnerable women and young people.

National laws, policies and strategic frameworks recognize the progressive realization of the right to health; to decide on the number of children and timing and spacing of births; to education and information; and to gender equality and freedom from all forms of violence and discrimination. However, gaps exist in effective and efficient implementation of priority interventions required to actualize the targets in the revised sixth national development plan, Vision 2030 and the Sustainable Development Goals (SDGs).

Zambia's national statistical system, though improving in its institutional capacity to generate and analyse disaggregated data, requires improved capacities at provincial and district levels to generate timely disaggregated data by geographic location, sex, wealth quintile and age groups. Further use of disaggregated data in the design of plans, strategies and targeted interventions at national, provincial and district levels is required to address the socioeconomic disparities in the country.

3. UNFPA Programmatic Support to Zambia

The 8th Country Programme (8CP) responds to national priorities and is guided by analytical studies and assessments, and benefited from multi-sectoral consultations with the Government, civil society organizations, academia, the private sector, young people and United Nations organizations. It is aligned to the revised sixth national development plan, Vision 2030, the United Nations Sustainable Development Partnership Framework (2016-2020) and UNFPA Strategic plan (2014-2017). In 2018, the country office undertook the process of aligning the 8CP to the 2018-2021 Strategic Plan. The 2018–2021 Strategic Plan is the first of three UNFPA strategic plans leading to 2030. It focuses on the three transformative results; (i) ending unmet need for family planning, (ii) ending preventable maternal deaths, and (iii) and ending violence and harmful practices including child marriage. These transformative results will contribute to the achievement of the SDGs, in particular, good health and well-being, the advancement of gender equality, and the empowerment of women and adolescent girls, with a focus on eradicating poverty. The Country office is addressing all the three transformative results.

The programme is results-focused and builds on the experiences of targeted geographic focus. The programme supports national-level policies, programme design and nation-wide interventions, while providing targeted support to marginalized population groups, and underserved districts in six provinces to ensure continuity and significant programme coverage aimed at addressing some of the issues identified in the situation analysis.

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The 8CP contributes to three outcomes of the 2014-2017 UNFPA Strategic Plan and intends to achieve the following results with an overall focus on women and young people particularly adolescent girls.

Outcomes

- Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access
- Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health
- Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality

Outputs

- National, provincial and district institutions have increased capacity to deliver gender-sensitive sexual and reproductive health and HIV services
- National, provincial and district institutions have the capacity to increase demand for and improve supply of life-saving reproductive health commodities and medicines, including modern contraceptives
- Increased capacities of national, provincial and district institutions to design, implement and monitor comprehensive sexuality education programmes that promote human rights and gender equality
- Increased capacity of national, provincial and district institutions to design and implement comprehensive programmes for marginalized adolescent girls, including safe spaces, for those at risk of child marriage
- Increased availability of disaggregated evidence through cutting-edge data generation and in-depth analysis of population dynamics, sexual and reproductive health, HIV, and gender-equality outcomes

GRZ/UNFPA 8th Country Programme Results Framework

Goal: Achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the ICPD agenda

UNFPA Strategic Areas		
I. Sexual and reproductive health	**II. Adolescents and youth**	**IV. Population dynamics**
UNFPA Strategic Outcomes		
Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access	Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health	Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality
UNFPA Zambia 8th Country Programme Outputs		
1. National, provincial and district institutions have increased capacity to deliver gender-sensitive sexual and reproductive health and HIV services 2. National, provincial and district institutions have the capacity to increase demand for and improve supply of life-saving reproductive health commodities and medicines, including modern contraceptives	1. Increased capacities of national, provincial and district institutions to design, implement and monitor comprehensive sexuality education programmes that promote human rights and gender equality 2. Increased capacity of national, provincial and district institutions to design and implement comprehensive programmes for marginalized adolescent girls, including safe spaces, for those at risk of child marriage	1. Increased availability of disaggregated evidence through cutting-edge data generation and in-depth analysis of population dynamics, sexual and reproductive health, HIV, and gender-equality outcomes
UNFPA Zambia 8th Country Programme Intervention Areas		
1.1 Develop the capacity of health-care providers on effective planning, delivery and monitoring of high-quality emergency obstetric and neonatal care services, including post-abortion care, as well as maternal death surveillance and response, in line with international standards and guidelines 1.2 Implement evidence-based advocacy and technical support for the establishment of accountability frameworks to monitor quality midwifery production, deployment and retention, especially in underserved areas	1.1 Targeted capacity development of provincial and district-level staff to strengthen innovative out-of-school programmes that scale up equitable access to high-quality, youth-friendly and gender-sensitive sexual reproductive health information and services, including HIV prevention 1.2 Reviewing in-school comprehensive sexuality education curricula to ensure incorporation and delivery of gender-sensitive sexual reproductive health components through school grades 5 to 12	1.1 Capacity development of national, provincial and district-level institutions to undertake data generation, in-depth analysis and utilization of disaggregated data by age, sex, wealth quintile and geographic location, to inform national development processes, including humanitarian preparedness and response 1.2 Evidence-based advocacy for integration of population variables in the seventh national development plan and sector policies, programmes, budgets and expenditure frameworks

1.3 Institutionalize routine fistula case identification, treatment and linkages to social reintegration programmes, in line with international standards 1.4 Rollout sexual reproductive health and HIV linkages service models at health facility levels, alongside health sector response for gender-based violence 1.5 Support the design and delivery of the Minimum Initial Service Package in humanitarian settings within the national contingency plan 1.6 Promote evidence-based and innovative demand-creation interventions that address social norms and cultural practices limiting equitable access to sexual reproductive health and HIV services 1.7 Support multi-sectoral coordination mechanisms at national and provincial levels that advance sexual reproductive health issues 2.1 Implement evidence-based advocacy to increase domestic funding for public sector procurement needs for modern contraceptives and life-saving maternal health medicines, while meeting procurement shortfalls 2.2 Develop capacity for evidence-based forecasting, quantification, logistics and supply chain management systems, including last-mile distribution from national to health facility levels 2.3 Support innovations and documentation of success factors that improve delivery of gender-sensitive family planning services, including male and female condoms, within marginalized and key populations	1.3 Supporting national and provincial level policy coherence and multi-sectoral coordination mechanisms for youth health and development programmes 2.1 Implement and monitor national strategies and community-based programmes, such as child marriage free zones and effective community support systems with active male involvement, aimed at ending child marriages, addressing teenage pregnancy and ending sexual gender-based violence 2.2 Foster strategic partnerships to build social and economic assets of women and adolescent girls through safe spaces 2.3 Design of accountability mechanisms that enforce legislative and policy actions on the legal age of marriage and improve access to sexual reproductive health services	1.3 Empowering women and young people to engage in policy dialogues on the rights of women and young people in national development processes

4. Objectives and Scope of the Evaluation

The overall **objectives** of the 8th CPE are:

i. enhancing the accountability of UNFPA for the relevance and performance of the country programmes;
ii. broadening the evidence base for the design of the next programming cycle; and
iii. generating a set of clear forward-looking and actionable recommendations logically linked to the findings and conclusions. These recommendations will include specific guidance on the development of the 9th country programme.

Specifically, the CPE aims to:

(i) Provide an independent assessment of the relevance, effectiveness, efficiency and sustainability of UNFPA support and progress towards the expected outputs and outcomes set forth in the results framework of the country programme;

(ii) Provide an assessment of the country office's positioning within the developing community and national partners, in view of its ability to respond to national needs while adding value to the country development results;

(iii) Provide an assessment of the role played by the UNFPA country office 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

(iv) Assess the extent to which the implementation framework enabled or hindered achievements of the results chain i.e. what worked well and what did not work well;

(v) Draw key lessons from past and current cooperation and provide a set of clear and forward- looking options leading to strategic and actionable recommendations for the next programming cycle.

Scope of the Evaluation

The evaluation will cover interventions planned and/or implemented within the current country programme during the period 2016-2019. The evaluation will cover all/the following provinces where UNFPA implemented interventions: Western, North Western, Luapula, Central, Lusaka and Copperbelt. The evaluation will also cover the technical areas of the 8CP namely; Sexual and Reproductive Health, Adolescents and Youths and Population Dynamics. In addition, the evaluation will cover crosscutting aspects such as human rights-based approach, gender and disability mainstreaming, coordination, monitoring and evaluation, and partnerships.

5. Evaluation Criteria and Evaluation Questions

In accordance with the methodology for CPEs as outlined in the UNFPA Handbook: How to Design and Conduct Country Programme Evaluations 2019 (https://www.unfpa.org/EvaluationHandbook), the evaluation will assess the relevance of the 8CP including the capacity of the CO to respond to the country needs and challenges. The evaluation will also assess progress in the achievement of outputs and outcomes against what was planned (effectiveness) in the country Programme Results and Resources Framework (RRF), efficiency of interventions in terms of human as well as financial resources and sustainability of results. The focus of the evaluation is summarized in the table below;

Relevance	The extent to which the objectives of the UNFPA country programme correspond to population needs at country level (in particular, those of vulnerable groups), and were aligned throughout the programme period with government priorities and with strategies of UNFPA. The ability to ***respond*** to: (i) changes and/or additional requests from national counterparts, and (ii) shifts caused by external factors in an evolving country context
Effectiveness	The extent to which intended outputs have been achieved and the extent to which these outputs have contributed to the achievement of the outcomes.

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Efficiency	How funding, personnel, administrative arrangements, time and other inputs contributed to, or hindered the achievement of results
Sustainability	The extent to which the benefits from UNFPA support are likely to continue, after it has been completed
Coordination	The extent to which UNFPA has been an active member of, and contributor to existing coordination mechanisms of the UNCT

The indicative questions based on the above main components are given below:

Relevance

1. To what extent is the country programme adapted to: national needs and policies; priorities of the programme stakeholders and target groups; the goals of the International Conference on Population and Development (ICPD) Programme of Action, SDGs, and the strategies of UNFPA?
2. To what extent has the country office been able to respond to changes in national needs and priorities caused or to shifts caused by major political change? What was the quality of the response?

Effectiveness

1. To what extent did the interventions supported by UNFPA in all programmatic areas contribute to the achievement of planned results (outputs and outcomes)? Were the planned geographic areas and target groups successfully reached?
2. To what extent has the programme integrated gender and human rights-based approaches?

Efficiency

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

Sustainability

1. To what extent have UNFPA supported interventions contributed to the development of capacities of its partners?
2. To what extent have the partnerships established by UNFPA promoted the national ownership of supported interventions, programmes and policies?

Coordination

1. To what extent has the UNFPA Country Office contributed to the functioning and consolidation of UNCT coordination mechanisms?

The final evaluation questions and the evaluation matrix will be finalized by the evaluation team in the design report.

6. Methodology and Approach

6.1 Approach

The evaluation should be transparent, inclusive, participatory, and responsive to gender and human rights. The evaluation team will use a mixed-method approach including document review, group and individual key informant interviews, focus group discussions, observations and field visits as appropriate. Quantitative methods will encompass compiling and analysing quantitative secondary data through relevant reports, financial data, and indicator data. Quantitative data will be used to assess trends in programming, investment and outcomes. This information will be complemented by qualitative methods for data collection consisting of document review, interviews, focus group discussions and observations through field visits.

These complementary approaches described above will be deployed to ensure that the evaluation:

a) Responds to the needs of users and their intended use of the evaluation results;
b) Integrates gender and human rights principles throughout the evaluation process, including participation and consultation of key stakeholders (rights holders and duty-bearers) to the extent possible;

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c) Provides credible information about the extent of results and benefits of support for beneficiaries and stakeholders.

The country programme evaluation will be carried out in accordance with the 2019 UNFPA Evaluation Policy. The work of the evaluation team will be guided by the Norms and Standards established by UNEG. Team members will adhere to the Ethical guidelines for
Evaluators in the UN system and the Code of Conduct (see Annex 2), also established by UNEG. The evaluators will be requested to sign the Code of Conduct prior to engaging in the evaluation exercise. The evaluation will also follow the guidance on the integration of gender equality and human rights as established in the UNEG guidance document "*Integrating Human Rights and Gender Equality in Evaluations*".

The evaluation will adopt an inclusive and participatory approach, involving a broad range of partners and stakeholders at both national and sub-national levels. The evaluation will ensure the participation of women, girls and youths in particular, those from vulnerable groups of targeted populations.

6.2 Methodology

Final

The evaluation methodology will be guided by the UNFPA's Evaluation Handbook (2019) mentioned earlier, which provides a detailed approach to UNFPA evaluations. The evaluation team is strongly encouraged at all times to refer to the Handbook including specific templates for use at different stages of the evaluation process (https://www.unfpa.org/sites/default/files/admin-resource/UNFPA_Evaluation_Handbook_FINAL_Chap7.pdf). The CPE evaluation must be designed to meet the objectives spelt out under section four by using contribution analysis as its central, theory based analytical approach. The **theory-based approach** means that the evaluation methodology will be based on the careful analysis of the intended outcomes, outputs, activities, and the contextual factors and their potential to achieve the desired outcomes. The analysis of the country programme's Theory of Change (ToC), and the reconstruction of its intervention logic, as necessary, will therefore play a central role in the design of the evaluation, in the analysis of the data collected throughout its course, in the reporting of findings, and in the development of conclusions and of relevant and practical recommendations. The ToC reflects the conceptual and programmatic approach taken by UNFPA Zambia over the period under evaluation including the most important implicit assumptions underlying the change pathway. The ToC will include intervention strategies and modes of engagement used in program delivery, guiding principles, the intervention logic and causal links, expected changes as well as risk factors and critical assumptions. The evaluation team will be expected to represent the ToC in a diagram as part of the inception report. The ToC will be also be tested during the field and data collection phase.

Evaluators will base their assessment on the analysis and interpretation of the logical consistency of the chain of effects: linking programme activities and outputs with changes in higher-level outcome areas, based on observations and data collected along the chain. This analysis should serve as the basis of a judgment by the evaluators on how well the programme under way is contributing to the achievement of the intended results foreseen in the country programming documents.

The evaluation team will develop the evaluation methodology in line with the Evaluation Handbook and design corresponding tools to collect data and information as a foundation for valid, evidence-based answers to the evaluation questions and an overall assessment of the country programme. The methodological design will include: an analytical framework; a strategy for collecting and analysing data; specifically designed tools; an evaluation matrix; and a detailed work plan. The Evaluation Handbook is designed as a practical guide to help the evaluation team apply methodological rigour to the design and implementation of the CPE. It is expected that the evaluation team is well acquainted with the Handbook at inception stage of the CPE.

Finalization of the Evaluation Questions and Assumptions

The finalization of the evaluation questions that will guide the evaluation should clearly reflect the evaluation criteria and indicative evaluations questions listed in the present terms of reference. They should also draw on the findings from the reconstruction of the intervention logic of the country programme. The evaluation questions will be included in the evaluation matrix (see Annex 8) and must be complemented by sets of assumptions that capture key aspects of the intervention logic associated with the scope of the question. The data collection for each of the assumptions will be guided by clearly formulated quantitative and qualitative indicators also indicated in the matrix.

Data Collection

Data will be collected via multiple approaches including documentary review, group and individual interviews, focus groups and field visits as appropriate. The evaluation will consider both secondary and primary sources for data collection. Secondary sources will inform the desk review that will focus primarily on programme reviews, progress reports, monitoring data gathered by the country office in each of the programme components, evaluations and research studies conducted and large scale and other relevant data systems in country. Primary data collection will include semi-structured interviews at national and subnational level with beneficiaries, government officials, and representatives of implementing partners and civil society organizations and other key informants. Field visits will be conducted on sample basis during which focus group discussions will be conducted with beneficiaries and observations will provide additional primary data. Data is to be disaggregated by sex, age and location, where possible.

Data collection methods will be linked to the evaluation criteria, evaluation questions and assumptions that are included within the scope of the evaluation. The evaluation matrix[157] will be utilized to link these elements together.

The evaluation team is expected to spend three weeks in Zambia meeting with stakeholders at national and sub-national levels. The proposed field visit sites, stakeholders to be engaged and interview protocols will be outlined in the inception report to be submitted by the evaluation team. When choosing sites to visit, the evaluation team should make explicit the reasons for selection. The choice of the locations to visit at sub-national level needs to take into consideration the implementation of UNFPA's program components in those areas and done in consultation with the evaluation manager and Evaluation Reference Group (ERG).

Data Analysis

The focus of the data analysis process in the evaluation is the identification of evidence. The evaluation team will use a variety of both quantitative and qualitative methods to ensure that the results of the data analysis are credible and evidence-based. The analysis will be undertaken at the level of programme outputs and their contribution to outcome level changes.

Evaluation questions set within the change pathway of the ToC will be tested to assess change as well as UNFPA's contribution to the changes observed over the years. The reconstructed ToC and the assumptions therein will be tested during the conduct of the evaluation. Determination of progress will be based on data responding to the indicators in the evaluation matrix. By triangulating all data from all sources and methods, a comprehensive picture should emerge on the validity of the reconstructed ToC, and UNFPA's contribution to the change observed.

Validation mechanisms

All findings of the evaluation need to be supported with evidence. The evaluation team will use a variety of methods to ensure the validity of the data collected. Besides a systematic triangulation of data sources and data collection methods and tools, the validation of data will be sought through regular exchanges with the UNFPA Zambia Country Office programme managers and other key program stakeholders. A validation workshop with members of the ERG and other key stakeholders will be conducted at the end of the field phase.

Limitations to the methodology

[157] The evaluation matrix specifies the evaluation; the particular assumptions to be assessed under each question; the indicators, the "sources of information" (where to look for information) that will be used to answer the questions; and the methods and tools for data collection that will be applied to retrieve the data. The evaluation matrix must be included in the design report as an annex. During the field phase, the matrix will be used as a reference framework to check that all evaluation questions are being answered. At the end of the field phase, evaluators will use the matrix to verify that enough evidence has been collected to answer all the evaluation questions. The evaluation matrix must be included in the final report as an annex.

Final

The evaluation team will identify possible limitations and constraints during the data collection phase and present mitigating measures in the draft report.

7. Evaluation Process

The evaluation will be undertaken in five phases: (i) preparatory phase, (ii) design phase, (iii) field phase (iv) reporting phase (v) facilitation of use and dissemination phase. Quality assurance measures should be integrated in all the phases to ensure high quality work.

i) ***Preparatory Phase***

- Preparation and approval of the Terms of Reference (ToR)
- Constitution of the reference group for the ERG
- Selection, prequalification and hiring of the evaluation team
- Collection of relevant documents regarding the country programme for the period being examined
- Preparation of a stakeholder map (see Annex 4) - the Evaluation Manager will prepare a preliminary mapping of stakeholders relevant to the evaluation (to be provided to the evaluation team)
- Development of a communication plan for sharing results - as the evaluation progresses, any new opportunities for communication and dissemination should be identified and the plan should be updated accordingly.

ii) ***Design Phase***

During this phase, the evaluation team will complete:

- A document review of all relevant documents available at the UNFPA Zambia Country Office and UNFPA Headquarters regarding the GRZ/UNFPA 8CP
- A stakeholder mapping - The evaluation team, in consultation with the ERG, will perform a stakeholder mapping in order to identify both UNFPA direct and indirect partners (i.e. partners who do not work directly with UNFPA and yet play a key role in a relevant outcome or thematic area in the national context). The stakeholders may include representatives from the government, civil society organizations, the private sector, UNFPA, peer UN organizations, other multilateral organizations, bilateral donors, and most importantly, the beneficiaries of the programme;
- Assess limitations to the data collection process and provide mitigation measures.
- An analysis of the results matrix and reconstruction of the intervention logic of the programme i.e. the theory of change meant to lead from planned activities to the intended results of the programme;
- The finalization of the list of evaluation questions;
- Preparation of the evaluation matrix
- The development of a data collection and analysis strategy, as well as a concrete work plan for the field phase

At the end of the design phase, the evaluation team will produce a **design report** describing the results of the above-listed steps and tasks. An **evaluation matrix** will accompany the design report highlighting the core elements of the evaluation: a) *what* is to be evaluated (evaluation criteria, questions and assumptions) and b) *how* to evaluate - the sources of information and methods and tools for data collection.

iii) ***Field Phase***

The evaluation team will undertake a three-week in-country mission to collect and analyse the data required in order to answer the evaluation questions consolidated at the design phase. Fieldwork will commence with a briefing to CO staff on the evaluation.

At the end of the field phase, the evaluation team will provide the CO with a debriefing presentation on the preliminary results of the evaluation, with a view to validating preliminary findings and testing tentative conclusions and/or recommendations.

iv) ***Reporting Phase***

Final

During this phase, the evaluation team will continue the analytical work initiated during the field phase and prepare a **first draft of the final evaluation report**, taking into account comments made by the Country Office at the debriefing meeting. This first draft final report will be submitted to the ERG for comments (in writing) while respecting the independence of the evaluation team in expressing its judgment. The Evaluation Manager in coordination with the ESA Regional M&E advisor will use the Evaluation Quality Assessment Grid to assess the quality of the draft evaluation report.

Comments made by the reference group and consolidated by the Evaluation Manager will then allow the evaluation team to prepare **a second draft of the final evaluation report**. This second draft report will form the basis of a validation and dissemination seminar, which should be attended by the country office, as well as all the key programme stakeholders (including key national counterparts).

The **final report** will be drafted shortly after the seminar, taking into account comments made by the participants. The consultants will be invited to look at good quality CPE reports that can be found on the UNFPA evaluation database at https://web2.unfpa.org/public/about/oversight/evaluations/. These must be read in conjunction with their Evaluation Quality Assessment (EQA) (also available in the database) in order to gain a clear idea of the quality standards expected the evaluation team.

*v) **Facilitation of use and dissemination phase***

During this phase, the evaluation manager together with the Communications Analyst will implement the communication plans to share the evaluation results with the CO, Regional Office (RO), ERG, implementing partners and other stakeholders. The evaluation manager also makes sure that the final evaluation report is communicated to relevant business units in the CO, invites them to submit a management response and consolidates all responses in a final management response document (see Annex 7).

The final evaluation report, along with the management response, and EQA of the report will be published on the UNFPA evaluation database. The evaluation report will also be made available to the UNFPA Executive Board and will be published on the CO website (https://zambia.unfpa.org/en/publications)

8. Expected Outputs/deliverables

The evaluation will be expected to produce the following deliverables:

- A design/inception report (*maximum 30 pages*) including (as a minimum): (a) a stakeholder mapping; (b) the evaluation matrix (including the final list of evaluation questions and indicators); (c) the overall evaluation design and methodology, with a detailed description of the data collection plan for the field phase; (see Annex 5)
- Debriefing presentation documents (Power Point) synthesizing the evaluation design and later, main preliminary findings, conclusions and recommendations of the evaluation, to be presented and discussed with the country office during the debriefing meeting foreseen at the end of the field phase;
- A final evaluation report *(maximum 70 pages plus annexes)*. This will be potentially followed by a second draft, taking into account comments from the ERG; (see Annex 5)
- A PowerPoint presentation of the results of the evaluation for the validation and dissemination seminar
- A final evaluation report based on recommendations from the validation and dissemination seminar.

Quality Assurance

The CPE has a three-stage evaluation quality assessment (EQA) of the final evaluation report. The first level of quality assurance of all evaluation deliverables will be conducted by the **evaluation team leader** prior to submitting the deliverables to the review of the CO.

The CO recommends that the evaluation quality assessment checklist (see below) is used as an element of the proposed quality assurance system for the draft and final versions of the evaluation report. The main purpose of this checklist is to ensure that the evaluation report complies with evaluation professional standards.

1. Structure and Clarity of the Report

Final

To ensure report is user-friendly, comprehensive, logically structured and drafted in accordance with international standards.
2. Executive Summary To provide an overview of the evaluation, written as a stand-alone section including key elements of the evaluation, such as objectives, methodology and conclusions and recommendations.
3. Design and Methodology To provide a clear explanation of the methods and tools used including the rationale for the methodological choice justified. To ensure constraints and limitations are made explicit (including limitations applying to interpretations and extrapolations; robustness of data sources, etc.)
4. Reliability of Data To ensure sources of data are clearly stated for both primary and secondary data. To provide explanation on the credibility of primary (e.g. interviews and focus groups) and secondary (e.g. reports) data established and limitations made explicit.
5. Findings and Analysis To ensure sound analysis and credible evidence-based findings. To ensure interpretations are based on carefully described assumptions; contextual factors are identified; cause and effect links between an intervention and its end results (including unintended results) are explained.
6. Validity of conclusions To ensure conclusions are based on credible findings and convey evaluators' unbiased judgment of the intervention. Ensure conclusions are prioritised and clustered and include: summary; origin (which evaluation question(s) the conclusion is based on); detailed conclusion.
7. Usefulness and clarity of recommendations To ensure recommendations flow logically from conclusions; are targeted, realistic and operationally feasible; and are presented in priority order. Recommendations include: Summary; Priority level (very high/high/medium); Target (administrative unit(s) to which the recommendation is addressed); Origin (which conclusion(s) the recommendation is based on); Operational implications.
8. SWAP - Gender To ensure the evaluation approach is aligned with SWAP (guidance on the SWAP Evaluation Performance Indicator and its application to evaluation can be found at http://www.unevaluation.org/document/detail/1452 - UNEG guidance on integrating gender and human rights more broadly can be found here: http://www.uneval.org/document/detail/980)

The second level of quality assurance of the evaluation deliverables will be conducted by the **CO evaluation manager**.

Finally, the evaluation report will be subject to an independent assessment by the **UNFPA Evaluation Office (EO)**. The EO quality assurance system, based on the UNEG norms and standards and good practices of the international evaluation community, defines the quality standards expected from this evaluation. A key element is the EQA (see Annex 6), which sets out processes with in-built steps for quality assurance and outlines for the evaluation report and the review thereof. The EQA will be systematically applied to this evaluation. The evaluation quality assessment will be published along with the evaluation deliverables on the EO website at: https://web2.unfpa.org/public/about/oversight/evaluations/.

9. Workplan/Indicative Timeframe

CPE Phases and Task	March				April				May				June				July				August				Sept				Oct			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Preparatory phase																																
Drafting of the Terms of Reference																																
Review and approval of Terms of Reference by ESARO and EO																																
Pre-qualification of consultants																																
Recruitment of the evaluation team																																
Design phase																																
Evaluation Reference Group meeting																																
Understanding of the UNFPA strategic response, programmatic response																																
Submission of design/inception report by the evaluation team																																
Field phase																																
Data collection and analysis																																
Reporting phase																																
Debrief on fieldwork to CO																																
1st draft report																																
Feedback to draft report																																
2nd draft final report																																
Feedback on 2nd draft final report																																
Final report																																
Use, dissemination and management response phase																																
Quality assessment of final report																																
Dissemination among stakeholders																																
Management response preparation																																

Draft

10. Composition of the Evaluation Team

The evaluation will preferably be conducted by an evaluation team comprised of a team leader and two experts with expertise to cover each of the thematic area: i.e. a technical expert for each thematic programme area - (i) sexual and reproductive health (with a special focus on adolescents and youth; gender) and (ii) population and development (including gender mainstreaming). The team leader will also act as a technical expert evaluator for a programme component.

Roles and Responsibilities of the evaluation team

- The team leader will be responsible for the overall evaluation process and the production of the draft and final evaluation reports. S/he will lead and coordinate the work of the evaluation team during all phases of the evaluation and be responsible for the quality assurance of all evaluation deliverables. She/he will liaise with the Evaluation Manager at the CO on various issues related to successful completion of the evaluation exercise.

- The Team Leader is expected to be experienced in conducting complex type of evaluations, such as country programme evaluations, partnership evaluations, strategic evaluations, thematic multi-country evaluations. She/he will have overall responsibility for providing guidance and leadership in: development of the evaluation design including approach, methodology and workplan; drafting the design, draft and final reports, as well as brief summary for presentation at a dissemination workshop. The team leader will lead the CPE process and will provide guidance to the other team members. The Team Leader is expected to have a solid background in one of the two thematic areas of the country programme (sexual and reproductive health or population and development) and, in addition to his/her responsibilities as team leader, will serve as a thematic specialist in the Evaluation Team. The qualifications, experience and competencies of thematic specialists for each thematic area are described below;

- A sexual and reproductive health expert (Consultant) will provide expertise in integrated sexual reproductive health including adolescents/youth, HIV, gender, family planning and human resource management in the health sector. She/he will take part in the data collection and analysis work during the design and field phases. She/he will be responsible for drafting key parts of the design report and of the final evaluation report, including (but not limited to) sections relating to reproductive health and rights.

- A population and development expert (Consultant) will provide expertise in population and development issues (including census, democratic governance, population dynamics, monitoring and evaluation, legal reform processes, national and local capacity development and the national statistical system). She/he will take part in the data collection and analysis work during the design and field phases. She/he will be responsible for drafting key parts of the design report and of the final evaluation report, including (but not limited to) sections relating to population and development.

- All evaluators should assess the extent to which gender and human rights have been mainstreamed in the 8th country programme

11. Qualifications and Experience of the Evaluation Team

Team Leader

- An advanced degree in Social Sciences, Population Studies, Statistics or Demography.
- 10 years' experience in conducting complex evaluations in the field of development aid for UN agencies and/or other international organizations including experience in leading evaluations
- Expert experience in and knowledge of one of the thematic areas relevant to the country programme evaluation (either sexual and reproductive health and rights or population and development)
- Good knowledge of Zambia's national development context including sexual and reproductive health and rights, adolescent and youth, population and development and gender equality
- In-depth knowledge of evaluation methods, data collection and analysis
- Excellent data analysis skills in qualitative and quantitative methods;
- Experience in carrying out country programme evaluations
- Familiarity with UNFPA or UN operations;

Final

- Proven evaluation team leader experience
- Excellent analytical, writing and communication skills
- Experience working with a multi-disciplinary team of experts
- Excellent written and spoken English
- Where languages other than English will be used, the team leader will be assisted by subject matter experts, during the field phase for the conduct of the evaluation.

Sexual and reproductive health expert

- An advanced degree in Public Health, Medicine, Health Economics, Epidemiology or Biostatistics.
- 7 years' experience in conducting evaluations in the field of development aid for UN agencies and/or other international organizations;
- Substantive knowledge of sexual and reproductive health including adolescents and youth; gender as a thematic area
- Good knowledge of the national development context
- Knowledge of evaluation methods, data collection and analysis
- Excellent data analysis skills in qualitative and quantitative methods.
- Familiarity with UNFPA or UN operations;
- Excellent analytical, writing and communication skills
- Experience of operations and response to humanitarian/crisis an advantage
- Ability to work with a multi-disciplinary team of experts
- Ability to provide deliverables on time
- Excellent written and spoken English and local language skills

Population and development expert

- An advanced degree in Population studies, Statistics or Demography.
- 7 years' experience in conducting evaluations in the field of development aid for UN agencies and/or other international organizations;
- Substantive knowledge of population and development including gender mainstreaming as a thematic area
- Good knowledge of the national development context
- Knowledge of evaluation methods, data collection and analysis
- Excellent data analysis skills in qualitative and quantitative methods.
- Familiarity with UNFPA or UN operations;
- Excellent analytical, writing and communication skills
- Experience of operations and response to humanitarian/crisis an advantage
- Ability to work with a multi-disciplinary team of experts
- Ability to provide deliverables on time
- Excellent written and spoken English and local language skills

12.Remuneration and duration of the contract

Repartition of workdays among the team of experts will be the following:

	Team Leader	SRH Expert	P&D Expert
Design phase	9	4	5
Field phase	26	23	5
Reporting phase	25	12	10
Dissemination including stakeholder meeting	2	2	2
Consolidation of feedback from EO	3	-	-
TOTAL (days)	65	41	22

Final

The consultants will be paid an agreed daily rate within the UN consultants scale based on qualification and experience. Workdays will be distributed between the date of contract signature and end date of evaluation.

Payment fees will be based on the delivery of outputs, as follows:

- Upon approval of the design report; 20%
- Upon satisfactory contribution to the draft final evaluation report; 40%
- Upon satisfactory contribution to the final evaluation report; 40%

Daily subsistence allowance (DSA) will be paid per nights spent at the place of the mission following UNFPA DSA standard rates. Travel costs will be settled separately from the consultancy fees.

13.Management of the evaluation

The CPE will be conducted by the evaluation team and managed by the **Evaluation Manager** of the UNFPA Zambia CO. The evaluation manager will oversee the entire process of the evaluation, from its preparation to the dissemination of the final evaluation report and manage the interaction between the team of evaluators and the reference group. She will serve as an interlocutor between evaluation team and the ERG, facilitate, and provide general and logistical support as needed for the evaluation. The evaluation manager will ensure the quality control of deliverables submitted by the evaluation team throughout the evaluation process, communicate this through the EQA process in collaboration with the ESARO M&E advisor and prevent any attempts to compromise the independence of the team of evaluators during the evaluation process.

As per UNFPA's evaluation handbook, an **Evaluation Reference Group** will be established and be tasked to provide constructive guidance and feedback on implementation and products of the evaluation, hence contributing to both the quality and compliance of this exercise. The ERG will be coordinated by the Population and Development Department of the Ministry of National Development Planning. The ERG will be composed of the evaluation manager and other relevant staff from; the UNFPA country office in Zambia; Ministry of National Development Planning; Ministry of Health (national and sub-national levels in UNFPA supported provinces); Ministry of Chiefs and Traditional Affairs, Ministry of Gender; Ministry of Youth, Sports and Child Development; Central Statistical Office; Population Council; Planned Parenthood Association of Zambia (PPAZ); Young Women's Christian Association (YWCA); Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS) and the UNFPA East and Southern Africa Regional Office (ESARO). The main functions of the reference group will be:

- To discuss the terms of reference drawn up by the Evaluation Manager;
- To provide the evaluation team with relevant information and documentation on the programme;
- To facilitate the access of the evaluation team to key informants during the field phase;
- To discuss the reports produced by the evaluation team;
- To advise on the quality of the work done by the evaluation team;
- To assist in feedback of the findings, conclusion and recommendations from the evaluation into future programme design and implementation.

The roles and responsibilities of the **ESA Regional M&E advisor** are:

- Provides support (backstopping) to evaluation manager at all stages of the evaluation;
- Reviews and provides comments to the ToR for the evaluation;
- Assists the CO evaluation manager in identifying potential candidates and reviews the summary assessment table for consultants prior to it being sent to the EO;
- Undertakes the EQA of the draft final evaluation report;
- Provides support to the dissemination of evaluation results.

The roles and responsibilities of the HQ **Evaluation Office** are:

- Approves ToR for the evaluation after the review and comments by the ESA Regional M&E advisor (to be included in the draft ToR sent to the EO);
- Pre-qualifies consultants;
- Undertakes final EQA of the evaluation report;
- Publishes final report, EQA and management response in the evaluation database.

14.Bibliography and Resources

The following documents will be availed to the evaluation team upon recruitment using a Google Drive link.

1. UNFPA Strategic Plan (2014-2017) https://www.unfpa.org/resources/strategic-plan-2014-2017
2. UNFPA Strategic Plan (2018-2021) https://www.unfpa.org/strategic-plan-2018-2021
3. Zambia UNSDPF (2016-2021) http://zm.one.un.org/sites/default/files/final_zambia-united_nations_sustainable_development_partnership_framewor.pdf
4. Seventh National Development Plan http://www.mndp.gov.zm/wp-content/uploads/2018/05/7NDP.pdf
5. GRZ/UNFPA 8th Country Programme Document (2016-2020) https://zambia.unfpa.org/en/publications/unfpa-zambia-8th-country-programme-document
6. GRZ/UNFPA 8th Country Programme M&E Plan
7. Zambia Country Office Annual myResults Plans and Reports (2016, 2017, 2018) https://zambia.unfpa.org/en/publications/unfpa-zambia-annual-report-2016 https://zambia.unfpa.org/en/publications/unfpa-zambia-annual-report-2017 https://zambia.unfpa.org/en/publications/unfpa-zambia-annual-report-2018
8. Implementing Partner work plans and progress reports (2016, 2017, 2018)
9. Relevant national policy documents for each programmatic area
10. Demographic Dividend Study Report https://zambia.unfpa.org/en/publications/harnessing-demographic-dividend-future-we-want-zambia
11. UNFPA Zambia Resource Mobilization Strategy
12. Joint Programme Documents
13. Mid-Term Evaluation of the UNFPA Supplies Programme (2013-2020) https://www.unfpa.org/updates/mid-term-evaluation-unfpa-supplies-programme-2013-2020
14. Evaluation of H4+ Joint Programme Canada and Sweden (Sida) https://www.unfpa.org/updates/evaluation-h4-joint-programme-canada-and-sweden-sida
15. Evaluation of UNFPA support to the prevention, response to and elimination of gender based violence and harmful practices https://www.unfpa.org/updates/corporate-evaluation-unfpa-support-prevention-response-and-elimination-gender-based-violence
16. Reports on core and non-core resources
17. Donor reports
18. Evaluation Handbook: How to Design and Conduct a Country Programme Evaluation at UNFPA (2019) https://www.unfpa.org/EvaluationHandbook
19. UNEG Code of Conduct
20. UNEG Ethical guidelines
21. UNEG Guidance document - Integrating Human Rights and Gender Equality in Evaluations
22. UNEG Norms and Standards

Final

15. Annexes

1. UNEG Norms and Standards for Evaluation

UNEG Norms and Standards for Evalua

2. Ethical Code of Conduct of UNEG/ UNFPA Evaluations

Ethical Code of Conduct of UNEG_U

3. List of Atlas projects for the period under evaluation

List of Atlas Projects.docx

4. Information on main stakeholders by areas of interventions

The Stakeholder Map.docx

5. Outlines of the design and final evaluation reports

Design report structure.docx

Final report structure.docx

6. Evaluation Quality Assessment template

Evaluation Quality Assessment Templat

7. Management response template

Management Response Template.

8. Evaluation Matrix Template

Evaluation Matrix Template.docx

Final

Annex 2: Institutions and Persons Met

Key Informant Interviews, Group Interviews and Focus Group Interviews

Type of Stakeholder: UN Partners			
Organisation/ Agency	**Person(s) Met**	**Position & Office Location**	**Consultant Initials***
UNICEF	Mr. Nkandu Chilombo	Social Policy Specialist, Lusaka	VHC
UNESCO	Mr Remmy Mukonka	National Programme Officer	PN
UNICEF	Dr Shoo Dr Rogers Malik	Chief of Health, Lusaka Health Specialist, Lusaka	HJ
WHO	Dr Nathan Bakyaita	Country Representative, Lusaka	HJ
UNAIDS	Mr Nuha Ceesay	PEPFAR/ Global Fund Implementation Advisor, AIC, Lusaka	HJ
UNDP	Ms. Colleen Zimba	Economic Advisor, Lusaka	VHC
ILO	Mr Kelly Kaira	Programme Coordinator, Mansa, Luapula Province	HJ
Office of RC	Mr Paul Chitengi	UN Coordination Specialist, Lusaka	HJ
Type of Stakeholder: UNFPA			
		Country Office	
CO orientation meeting and presentations; two ERG meetings; one stakeholder meeting: all consultants			
	Ms Gift Malunga	Country Representative	HJ
	Ms Margaret Thwala-Tembe	Deputy Representative AI	HJ
	Ms Sibeso Mululuma	Assistant Representative (Lead: Population and Development)	HJ, VHC
	Ms Isabella A Phiri	Operations Manager	HJ
	Ms Rita Magawa	M&E Analyst	HJ
	Dr Stephen Mupeta	National Specialist RH (SRH, Maternal Health, EmONC, MDSR)	HJ
	Ms Lisa Gullbransson	Adolescent and Maternal Health Analyst	HJ
	Mr Justin Chongo	Programme Associate, Logistics	HJ
	Mr Frankline Echerue	Technical Specialist, GRID3	VHC
	Ms Jenipher Mijere	Fistula Analyst	HJ
	Ms Joy Manengu	National Specialist, ASRH and Youth	HJ, PN
	Ms Hayong Jeon	Youth Development Officer	PN, HJ
	Mr Benedictus Mangala	Consultant RMNCAH&N Programme	HJ
	Ms Womba Mayondi	Gender Analyst	HJ
	Ms. Mwaka Siamutwa	Programme Associate (Population and Development-Central Statistical Office Implementing Partner Manager)	VHC
	Ms. Precious Zandonda	Communications Analyst (Population Council Implementing Partner Manager)	VHC
	Mr Chimuka Hampango	Programme Analyst, RHCS	HJ
	Mr Michael Phiri	Finance and Admin Associate	HJ
		North-Western Province Sub-Office, Solwezi	
	Dr Nachilima Kaunda	Programme Coordinator	HJ
	Ms Mercy Kazungula	Programme Assistant	HJ
		Luapula Province Sub-Office, Mansa	
	Ms Elizabeth Kalunga	Provincial Coordinator	HJ
	Mr Conred Jani	Programme Assistant	HJ
		Western Province Sub-Office, Mongu	
	Mr Marshal Mizanda	Provincial Coordinator	PN
Type of Stakeholder: Government of Republic of Zambia			
MoH	Ms Caren Chizeni	Chief, Safe Motherhood, Lusaka	HJ
MoH	Mr Maxwell Kasonde	Commodity security, Lusaka	HJ
MoH	Ms Tina Chisenga	Deputy Director for Infectious Diseases, Lusaka	HJ
NAC	Ms Ellen Mubanga	Public Private Partnership Adviser and HIV Prevention Adviser, Lusaka	HJ

Ministry of National Development Planning	Rev. Charles Banda	Director (Population & Development), Lusaka	VHC
Ministry of National Development Planning	Ms. Pamela Kauseni	Assistant Director Policy (Population & Development), Lusaka	VHC
Ministry of National Development Planning	Mr. Happy Banda	Principal Planner (Population & Development), Lusaka	VHC
Central Statistical Office	Mr. Palver Sikanyiti	Senior Demographer, Lusaka	VHC
Surveyor General Office	Mr. Emmanuel Tembo	Project Manager-National Spatial Data Infrastructure, Lusaka	VHC
University of Zambia	Mr. Andrew Banda	Lecturer/Coordinator (GRID3), Lusaka	VHC
University of Zambia	Mr. Garikai Membele	Lecturer/Technical Consultant (GRID3), Lusaka	VHC
Ministry of General Education	Ms. Charity Banda	National HIV and Adolescent Health Coordinator, Lusaka	PN
Ministry of Chiefs and Traditional Affairs	Ms. Chileshe Kasoma	Principal Traditional Affairs Officer	PN
Ministry of Chiefs and Traditional Affairs	Ms. Patience Simutowe	Principal Chiefs Affairs Officer	PN
Ministry of Gender	Ms Namatama S Chinyama	Assistant Director, Gender Rights Protection	PN
Ministry of Youth and Sport	Mr Kakuwa Musheke	Planner	PN
		North-Western Province	
MoH, Provincial Health Office	Ms Hellen Mahamba	Principal Nursing Officer, MNCH	HJ, PN
MoH, Provincial Health Office	Dr Vivienne Lubinda	Acting Provincial Health Officer	HJ, PN
MoH District Office	Ms Grace Muleya	District Nursing Officer	HJ
Provincial Health Office	Mr Deputy Shanzala	Senior Health Education Officer	HJ, PN
	Ms Racheal Hamoonga Mafu	Assistant Accountant	
	Ms Catherine Chidumayo	Chief Pharmacist	
	Mr Clement Nawezhi	Senior Planner	
	Mr Ackim Machila	Planner	
	Mr Charles Mulenga	Principal Nursing Officer – Standards and Care	
	Mr Lawrence Mukombo	ICT Officer	
	Dr Jonathan Ncheengamwa	Clinical Care Specialist	
Ministry of General Education	Mr Dickson G. Mtonga	Senior Education Officer Guidance	PN
Ministry of Chiefs and Traditional Affairs	Ms Nosiku F Mulwana	Senior Traditional Affairs Officer	PN
	MrMwiingaBuumba	Traditional Affairs Minister	
Midwifery School, Solwezi	Mr Masiye Pumulo Ms Sarah Banda Ms Anna Kambafwile Ms Muhay Mumba	Head of College Acting Principal, Midwifery Clinical Instructor Clinical Instructor	HJ
MoH, District Health Office	Ms Grace Muleya Mr Caleb Konde	MCH Coordinator, Mufumbwe District Acting District Health Coordinator, Mufumbwe District	HJ, PN
Kashima Model Health Centre	Mr Jeremiah Tembo	Kashima Reproductive Health Coordinator and Midwife	HJ, PN
MoH, PHO	Dr Jonathan Ncheengamwa	Clinical Care Specialist	HJ, PN
Solwezi Day Secondary School	Ms Violet Mutoni Luputa	Head Teacher	PN
	Ms Careen Sibuku	Guidance Teacher	
GBV One Stop Shop	Esther Ng'onga,Paralegal	Solwezi General Hospital	PN, HJ
	Joyce Kahenge,Nurse		
	Abigail Mwandwe, Nurse		
	Fainess Mumba,Nurse		

Provincial NAC	Mr Hillary Sakala Mr David Manda Ms Lydia Malasha	Provincial AIDS Coordination Adviser Chairperson, District HIV/AIDS Committee, Solwezi District District AIDS Coordination Adviser, Solwezi District	HJ
	Ms Soneka Ndalama	In Charge, Registered Midwife, Boma	HJ
YWCA Solwezi	Ms Chileshe Mwape	Regional Coordinator	PN
	Mr Clement Sota	Safe Guarding Young People Coordinator	
		Luapula Province	
Luapula Province Administration	Dr Felix V Phiri	Provincial Permanent Secretary	HJ/PN
Provincial Planning Unit	Ms Queen Champo, Mr John Mukangile	Planners	HJ, PN
	Mr T Musandu	P/P	
	Ms Lucy Chabala, Ms Doris K Mwelwa	Senior Planners	
District Administration	Mr James Nyenjele	District Commissioner	
MoH Mansa General Hospital	Mr Aubrey Shangi	Fistula Surgeon, Mansa	HJ
PHO	Dr Peter Bwalya Dr Danny Katongo Mr Daniel Mulembwe Ms Mercy Kanswata Mr Haswell Malambo Mr Nathan Mwanza Mr Jackson Ngandwe Mr Cridence Kabwe Mr Nkandu Musunga Mr Chomba M Bwalya Mr Lucky Chifwesa Mr Jameson Kaunda Ms Angela Kawambwa	Provincial Health Director Public Health Specialist Principal Nursing Officer (Care and Standards) Acting Principal Nursing Officer (MNCH) Provincial RMNCAH&N Coordinator Senior Accountant Purchasing and Supplies Officer Accounts Assistant Planner Programme Manager Senior Health Promotions Officer Fistula Foundation M&E Officer Human Resource Development Officer	HJ, PN
Ministry of Home Affairs	Mr Emmanuel Ndhlovu	Deputy Refugee Officer, High Commissioner for Refugess	PN
District Health Office	Dr Gerald M Chongo	District Director of Health	PN
	Ms Selina Sisya	MCH Coordinator, Nchelenge	
	Ms Chisha Kamukwamba	MCH Coordinator, Mantapala	
Samfya Stage 2	Mr John Kaputulayi Ms Sylvia Mwenya	Clinical Officer, General Enrolled Nurse	HJ
Kasanka health facility	Ms Malambo Nchembele	General Clinical Officer, In-charge	HJ
Mansa College of Nursing and Midwifery	Ms Chewe Mubanga	Senior Tutor for General Nursing, Mansa	HJ
Zambian Agency for Persons with Disabilities, ZAPD	Mr Derrick Malama Ms Mwango Mwenya	Provincial Coordinator Assistant Coordinator Mansa, Luapula Province	HJ
YWCA	Ms Ethel B Mushili	Programme Officer	PN
	Ms Sheila Chanda	Site Coordinator	
Mantapala	Mr Bernard Banda Mr Musonda Chileshe Mr Cephas J Mulenga Ms Emelda Kabanda	Nurse in Charge Clinical Officer Environmental Health Technician EM	PN
Samfya District Health Office	Dr Kelvin Sinkala Mr Zacchus Lungu	District Health Director Clinical Care Officer	PN
Samfya	15 Peer educators, 7 females 8 males, aged 18	Samfya Stage II	PN

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	to 24		
Samfya Stage II	Ms Monica Nkhoma Ms Mumbuna Mwakamui	Secretary, School Health Committee Secretary, School Health Committee	PN
Kasanka Rural Health Hospital	Ms Malambo Nchembele	Clinical Officer General/In Charge	PN
MoGE, District Education Board	Mr Joseph Zgambo	District Education Standards Officer, Mansa	PN
		Western Province	
Mongu, Provincial Administration	Mr Sibanze Simuchoba	Permanent Secretary	PN
Provincial Health Office	Ms Catherine Matyola Mr Obbie Shibwangu Mr Akatama Inambao Mr Joseph S Mudenda	Principal Nursing Officer, MNCAH Planner SHEO Principal Nutritionist	PN
District Health Department, Kaoma	Dr Idi Mwinyi Ms Norah K Nawa Mr Misapa Chongo	District Health Director Maternal and Child Health Coordinator Planner	PN
Lewanika Hospital	Dr Samutumwa Njekwa Ms Pelina Phiri Chibanje	General Superintendent Principal Nursing Officer	PN
Lewanika College of Nursing and Midwifery	Ms Rosemary V Mwanza Ms Monde Nawa	Principal Tutor Registered Nurse Midwife (beneficiary)	PN
MoH Kasimba Rural Health Centre	Ms Mercy Mataa	Registered Nurse	PN
Kaoma General Hospital	Dr Banza Mukangala Mr Peter Kachama Mukushi	General Superintendent Digital Ultrasound Technician	PN
Senanga District Administration	Ms Ngombo Kabani	District Administration Officer (DAO)	PN
Senanga District Health Office	Dr Kambinda Likambi Mr Lililaelo Muyenga	District Health Director MCH Coordinator	PN
YWCA, Senanga	Ms Nalucha Hatontola	Project Coordinator	PN
		Central Province	
Provincial Administration	Mr Bernard Chomba	Permanent Secretary	PN
Provincial Health Office, Kabwe	Dr Charles Msiska Dr Isaac Banda Mr Sidney Monze	Provincial Health Director Public Health Specialist Planner	PN
District Health Office, Kabwe	Dr Jerry Sinyangwe	Acting District Health Director	PN
	Mr Swema Banda	Acting MCH Coordinator	
Ngungu Health Centre	Mr Kennedy Kama	Senior Clinical Officer	PN
	Ms Paida Bwalya	Nurse In Charge	
	Mr Gracious Katwishi	Trained Adolescent	
	Ms Ruth Chisanga	Nurse	
MoH Ngungu	2 SMAGs, one trained as TOT, both female	Ngungu Health Centre	PN
MoH Katondo Health Centre	Ms Kayreen K Chileshe	Registered Nurse Midwife/In Charge	PN
MoH health centre	14 peer educators, 2 female, 12 male, aged 14 to 28, both in-school and out of school	Katondo Health Centre	PN
MoH health centre	2 SMAGs, one fully trained, both female	Katondo Health Centre	PN

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MoH District Health Office, Kapiri	Dr Bavin Mulenga Ms Grace Lufungulo Mr Nathan Chanda Katongo Mr Nephas Banda	District Health Director MCH Coordinator Nursing Officer, Standards SEHO	PN
MoH Lukomba Health Centre	Mr Cosmas Chisanga Ms Carol Sinkende Ms Chilando Musonda Mr Paul Chisoka	Nurse Midwife Registered Nurse/FP and TOT Adolescent Health Registered Nurse/ART Focal Point Person ART Clinician	PN
MoH Lukomba health centre	6 peer educators, 2 female 4 male	Lukomba Health Centre	PN
Type of Stakeholder: International Development Partners, Donors			
DfID	Ms Silke Seco	Health Adviser, Lusaka	HJ
Sida/Sweden	Ms Ulrika Hertel	Health Adviser, Lusaka	HJ
Type of Stakeholder: Non-Government Implementing Partners, Civil Society			
Population Council	Mr Chabu Kangale	Population Council Adviser, Lusaka	VHC, HJ, PN
Library for the Visually Impaired	Mr Keshi Chisambi	Director, Lusaka	HJ, PN
Marie Stopes International	Mr Kwesi Formson	Country Director	HJ
Mansa Networking Committee of People Living with Disability	Mr Witness Kombe	Chairperson, Mansa, Luapula	HJ
Fistula Foundation	Ms Bwalya M Chomba	Programme Manager, Luapula	HJ
SAfAIDS	Ms Kudzai Meda	Programme Officer for Zambia, Lusaka	HJ
PPAZ	Mr Lester Phiri	Country Director, Lusaka	HJ
Medical Stores Limited	Ms Ilitongo Saasa Sondashi	Director Logistics, Lusaka	HJ
YWCA	Ms Debbie Chingobe	Project Coordinator, UNFPA Global Programme - Ending Child Marriage (ECM)/Safeguarding Young People (SYP) Programme, Lusaka	PN
YWCA	Mr Francis Phiri	Finance Officer, UNFPA Programmes, Lusaka	PN
YWCA	Ms Chileshe Mwape	Regional Coordinator, Solwezi, North Western Province	HJ/PN
YWCA	Mr Clement Sota	SYP Site Coordinator, Solwezi, North Western Province	HJ/PN
UN Youth Partnership Platform)	Mr Francis Jere	Chairperson, Lusaka	PN
Luapula Provincial Chief's Council	Senior Chief Mwewa	Chairperson, Luapula	PN
Type of Stakeholder: Primary and Secondary Beneficiaries, Focus Group Interviews			
		North-Western Province	
MoH Health Centre	SMAGs, 2 women, 1 man, secondary beneficiaries	Safe Motherhood Action Group (SMAGs) Mufumbwe District	HJ
MoH Health Centre	12 Peer educators, 7 males, 5 females, aged 17 to 25	Mufumbwe Rural Health Centre	PN
MoH Health Centre	Primary beneficiaries of SMAGs and CBDs, 5 women, 4 men	Kashima	HJ
MoH Health Centre	24 peer educators, 4 students, 4 girls, 20 boys	Kashima	PN
MoH Health Centre	Fistula survivor	Kashima	HJ
MoH Health Centre	3 antenatal mothers, first visit	Boma	HJ
MoH Health Centre	14 peer educators, aged 19 to 25, 6 female, 8 male, all out of school	Boma	PN
		Luapula Province	

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MoH Health Centre	SMAGs, 3 women 3 CBDs	Katanshya, Samfya District	HJ
MoH Health Centre	3 peer educators, 2 male, 1 female; 2 beneficiaries	Katanshya	PN
MoH Zonal Rural Health Centre Linkages Model Site	Large group of SMAGs and CBDs, mainly female, additional participants throughout FGI	Kasanka	HJ
	11 peer educators, aged 19 to 25, 7 female, 4 male	Kasanka	PN
MoH	3 CBDs, 2 male,1 female	Mantapala Refugee Settlement Rural Health Centre	PN
	2 peer educators, ages 35 and 31		PN
	16 SMAGs, 7 male, 9 female		PN
		Western Province	
Ending Child Marriage Project	2 mentors 1 male, 1 female	Senanga	PN
ECM Caprivi Community Safe Space	21 female members aged 15 to 20	Caprivi	PN
MoH	8 SMAGs, all female 1 CBD, male	Mulamba Rural Health Centre, Kaoma	PN
	2 peer educators, 1 male, 1 female		
MoH	2 male CBDs/ SMAGs/ CHWs	Kasimba Rural Health Centre	PN
	9 beneficiaries, all female		
		Central Province	
MoH	20 peer educators, aged 15 to 23, mixed group in school and out of school, 12 female, 8 male	Ngugu Health Centre, Kabwe	PN
MoH	11 SMAGs, 5 female, 6 male	Lukomba Health Centre, Kapiri Mposhi	PN
Site Observation			
		North-Western Province	
Kashima UNFPA Model Site		Kashima	HJ, PN
Maternity and Child Health Clinic		Mufumbwe District	HJ
Midwifery College		Solwezi	HJ
GBV One Stop Centre		Solwezi General Hospital	PN, HJ
		Luapula Province	
MoH Health centre		Katanshya	HJ
MoH Health centre adolescent corner		Katanshya	PN
MoH Health centre, Model Integrated Site		Kasanka	HJ
MoH health centre adolescent corner		Kasanka	PN
		Western Province	
Lewanika General Hospital, maternity wards		Mongu	PN
Lewanika School of Midwifery, administration block, skills laboratory and hostels		Mongu	PN
MoH health centre		Mulamba Model Integrated Site, Kaoma	PN
MoH health centre		Rural Health Centre, maternity and ART areas, Kasimba	PN
Caprivi ECM		Safe Space, Senanga	PN
		Central Province	
MoH health centre, Adolescent Corner		Ngungu, Kabwe	PN
MoH health centre, Adolescent Corner		Katondo, Kabwe	PN
MoH Model Integrated Site, Adolescent corner		Lukumba, Kapiri	PN

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Annex 3: Documents Consulted

Overarching Documents Consulted for CPE

1. UNFPA Strategic Plan (2014-2017)
2. UNFPA Strategic Plan (2018-2021)
3. Zambia UNSDPF (2016-2021)
4. Seventh National Development Plan 2017-2021
5. Seventh National Implementation Plan 2017-2021
6. GRZ/UNFPA 7th Country Programme Document (2011-2015)
7. GRZ/UNFPA 7th Country Programme Action Plan (2011-2015)
8. GRZ/UNFPA 8th Country Programme Document (2016-2020)
9. GRZ/UNFPA 8th Country Programme M&E Plan
10. Zambia Country Office Annual Reports (2015, 2016, 2017, 2018)
11. Zambia Country Office Annual Work Plans (2016, 2017, 2018, 2019)
12. Implementing Partner work plans and progress reports (2016, 2017, 2018)
13. Demographic Dividend Study Report
14. UNFPA Zambia Resource Mobilization Strategy
15. UNFPA (2019) Evaluation Handbook: How to Design and Conduct a Country Programme Evaluation at UNFPA
16. UNEG Code of Conduct
17. UNEG Ethical guidelines
18. UNEG Guidance document - Integrating Human Rights and Gender Equality in Evaluations
19. UNEG Norms and Standards

Documents Consulted for SRH Thematic Area

20. Ministry of Gender (2016) Zambia National Gender Knowledge, Attitudes and Practices Survey Report
21. Ministry of Health (2017) Zambia National Health Strategic Plan 2017-2021
22. Ministry of Health (2018) Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition Communication and Advocacy Strategy 2018-2021
23. Ministry of Health (2016) National Family Planning Social Behavioural Change Communication Strategy 2016-2020
24. Ministry of Health (2018) National Human Resources for Health Strategic Plan 2018-2024: Reshaping Zambia's Human Resources for Health to Become Self-Sufficient by 2030
25. Ministry of Health (2015) Health Sector Supply Chain Strategy and Implementation Plan 2015-2017
26. WHO (2016) WHO recommendations on antenatal care for a positive pregnancy experience
27. Ministry of Health (2017) Adolescent Health Strategy 2017-2021
28. Ministry of Health (July 2017) Nursing and Midwifery Protocols
29. Ministry of Health (2019) Health National Adaptation Plan
30. UNFPA (N/D) Lessons From the First Cycle of the Universal Periodic Review: From Commitment to Action on Sexual and Reproductive Health and Rights
31. UN Zambia (June 2017) Policy brief: Status of Sexual and Reproductive Health and Rights in Zambia: Contraception and Family Planning; Preventing Unsafe Abortion and Accessing Post Abortion Care; and Maternal Health
32. UN Zambia (June 2017) Policy brief: Status of Sexual and Reproductive Health and Rights in Zambia: Violence against Women and HIV/AIDS Prevention and Treatment
33. Mid-Term Evaluation of the UNFPA Supplies Programme (2013-2020)
34. Evaluation of H4+ Joint Programme Canada and Sweden (Sida)
35. Evaluation of UNFPA support to the prevention, response to and elimination of gender based violence and harmful practices
36. UNFPA GPS ID:119900 Comprehensive integrated SRHR/HIV/SGBV services (IP SAfAIDS)
37. GRZ (2015) National Guidelines for SRH, HIV and GBV Services Integration
38. GRZ/National AIDS Council (March 2017) A Comprehensive HIV Prevention Roadmap 2017-2021: Framework of Indicators and Targets
39. Actionaid (2018) Accountability for Women and Young People's SRH/HIV and SGBV in Zambia: Project Proposal 5 April 2018
40. NAC (2019) National Comprehensive Condom Programming Strategy 2018-2021
41. UNFPA (2010) Comprehensive Condom Programming: a guide for resource mobilization and country programming
42. MoH (2018) National Roadmap to Support Scale-up of Intramuscular and Subcutaneous DMPA by Community Based Distributors in Zambia (2018-2021)
43. NAC (March 2017) A Comprehensive HIV Prevention Roadmap 2017-2021: Framework of Indicators and Targets
44. NAC (September 2017) Zambia National HIV Prevention Coalition Road map: Results of the Stocktaking Exercise
45. UN Zambia (2019) Final Report: The Millennium Development Goal Initiative: Accelerating Progress towards Maternal, Neonatal and Child Morbidity and Mortality Reduction in Zambia
46. UNICEF Zambia CO (2019) The Millennium Development Goal Initiative Progress and Utilization Report, Jan-Dec 2018
47. GRZ-EU-UN MDGi Key Results and Lessons: presentation to Final Steering Committee Meeting, 13 August 2019

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48. Population Council et al (2017) Policy Brief: The Status of Sexual and Reproductive Health and Rights in Zambia: Contraception and Family Planning, Preventing Unsafe Abortion and Accessing Post-Abortion Care, and Maternal Health
49. Population Council et al (2017) Policy Brief: The Status of Sexual and Reproductive Health and Rights in Zambia: Violence Against Women and HIV/AIDS Prevention and Treatment
50. MoH (2015) National Guidelines for SRH, HIV and GBV Services Integration

Documents Consulted for Adolescents and Youth Thematic Area

51. Republic of Zambia Central Statistics Office (CSO) (2016) Living Conditions Monitoring Survey Report
52. Republic of Zambia (2015) National Youth Policy
53. Ministry of Gender (2016) National Strategy on Ending Child Marriages 2016-2021
54. UKAID/Population Council/YWCA, Adolescent Girls Empowerment Programme - Health and Life Skills Curriculum
55. Zambia YWCA/UNFPA Working with Boys and Young Men Training Curriculum
56. Ministry of Gender (2016) Movers and Models for Ending Child Marriage in Zambia, National Advocacy and Communication Strategy on Ending Child Marriage in Zambia 2018-2021
57. SAfAIDS (2018) Technical Concept Safe and Secure (SaSe!) - the Integrated Approach to Contributing to a Safe and Secured Nation of Adolescents and Young People from SRH Challenges in Zambia
58. Ministry of Health Adolescent Health Strategy 2017-2021
59. Ministry of General Education and Ministry of Higher Education (2017) Education and Skills Sector Plan 2017-2021
60. Republic of Zambia/UNFPA/SYP/YWCA Adolescent Friendly Health Services Referral Card
61. Ministry of Gender (2014) National Gender Policy, Lusaka, Zambia
62. Ministry of Gender (2011), Anti-Gender Based Violence Act No. 1 of 2011, Lusaka, Zambia
63. Japan International Cooperation Agency (JICA) Japan Development Service Co., Ltd. (JDS) (2016) Country Gender Profile: Zambia Final Report, Lusaka, Zambia
64. Ministry of Gender, GBV National Guidelines (2011)
65. Population Council/UNFPA (2018) State of the Youth in Zambia Policy Brief: Education, Unemployment, and Poverty Reduction
66. Ministry of Health (2018) National Youth Consultation Meeting on Primary Health Care Outcome Report
67. Ministry of Health (2015) National Guidelines for SRH, HIV and GBV Services Integration
68. Ministry of Youth and Sports (2015) An Action Plan for Youth Empowerment and Employment
69. Ministry of Health (2012) Adolescent Health Policy Guidelines and Service Standards
70. Population Council et al (2017) Policy Brief: Child Marriage in Zambia
71. Population Council et al (2017) Policy Brief: The Status of Sexual and Reproductive Health and Rights in Zambia: Comprehensive Sexuality Health Education and Adolescents Sexual and Reproductive Health
72. Population Council et al (2017) Policy Brief: Adolescent Pregnancy in Zambia
73. Evaluation of UNFPA support to the prevention, response to and elimination of gender based violence and harmful practices

Documents consulted for Population Dynamics Thematic Area

74. Central Statistical Office. 2013. Population and Demographic Projections 2011-2035
75. Central Statistical Office. 2012. 2010 Census of Population and Housing Analytical Report
76. Ministry of Finance, Annual Economic Report 2018
77. United Nations Development Programme, Zambia Human Development Report 2016
78. Central Statistical Office. 2018. 2017 Labour Force Survey Report
79. Central Statistical Office, Zambia in Figures 2018
80. Central Statistical Office, Zambia Demographic and Health Survey Preliminary Report, 2018
81. Central Statistical Office, Zambia Demographic and Health Survey Report 2013/14
82. World Bank - https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=ZM
83. Ministry of Health, Zambia Population-based HIV Impact Assessment 2016
84. UNAIDS 2017 - https://www.unaids.org/en/regionscountries/countries/zambia
85. Ministry of Health, National Tuberculosis Prevalence Survey 2013-2014
86. Ministry of General Education, Educational Statistical Bulletin, 2017
87. National Assembly of Zambia - http://www.parliament.gov.zm/members/gender
88. Ministry of Finance. 2015. Harnessing the Demographic Dividend: The future we want for Zambia
89. Ministry of National Development Planning. 2018. The sub-national analysis report
90. Ministry of National Development Planning and UNFPA. 2016. Sub-national population situation analysis for national development planning in Zambia
91. United Nations-Zambia. 2017. Rapid Country Profile
92. Ministry of National Development Planning and UNFPA. 2017. Provincial level indicator analysis report: Luapula Province
93. World Bank and Central Statistical Office. 2015. Mapping sub-national poverty in Zambia
94. Government of Zambia. 2018. The Statistics Act 2018

Final

95. Central Statistical Office. 2019. Background to the 2020 Census Questions
96. Ministry of National Development Planning. 2018. 7NDP Implementation Plan 2017-2021. Volume II
97. United Nations - Zambia. 2019. Rapid Integrated Assessment of Zambia's 7th National Development Plan (2017-21) Volumes 1 & 2
98. Ministry of National Development Planning and United Nations-Zambia. 2018. Zambia SDGS Coordination and Implementation Framework 2017-2030: Zambia SDGS Roadmaps: A Guide to Implementation of Sustainable Development Goals 2017-2023.
99. Central Statistical Office. 2014. National Strategy for the Development of Statistics (NSDS)
100. Statistics Act 2018.

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Annex 4: Atlas Projects

IA Code	Implementing Partner	Geographic Location	Fund
POPULATION DYNAMICS			
Strategic Plan outcome: *Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality*			
Country programme output: *Increased availability of disaggregated evidence through cutting-edge data generation and in-depth analysis of population dynamics, sexual and reproductive health, HIV, and gender-equality outcomes*			
PGZM32	Ministry of National Development Planning	• National	RR, OR
PGZM19	Central Statistical Office	• National	RR, OR
PN6553	Population Council	• National	RR, OR
SEXUAL REPRODUCTIVE HEALTH AND RIGHTS			
Strategic Plan outcome: *Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access*			
Country programme output (i): *National, provincial and district institutions have increased capacity to deliver gender-sensitive sexual and reproductive health and HIV services*			
Country programme output (ii): *National, provincial and district institutions have the capacity to increase demand for and improve supply of life-saving reproductive health commodities and medicines, including modern contraceptives*			
PGZM11	Ministry of Health - HQ	• National	RR, OR
PGZM15	Provincial Health Office - North Western Province	• Solwezi, Mufumbwe, Chavuma, Zambezi district health offices • UNFPA model sites - Kashima (Mufumbwe), Chilenga (Zambezi) and Chiyeke (Chavuma) rural health centers • 15 other health facilities • St Francis • Solwezi School of Midwifery	RR, OR
PGZM16	Provincial Health Office - Luapula Province	• Mansa, Milenge, Samfya and Nchelenge district health offices • Mansa General Hospital • UNFPA model sites - East 7 (Milenge) and Kasanka (Samfya) • Other health facilities in Milenge district (Kapalala, Sokontwe, Mulumbi, Lwela, Kabange, Chibende) • Other health facilities in Samfya district (Shikamushile, Katanshya, Miponda, Fwaka, Mushili rural health centers)	RR, OR
PGZM17	Provincial Health Office - Western Province	• 16 districts and all health facilities • UNFPA focus districts (Kalabo, Kaoma and Lukulu) • UNFPA model sites - Wenela (kalabo), Mulamba (Kaoma) and Lubosi (Lukulu) rural health centers	RR, OR
PGZM31	Provincial Health Office - Central Province	• 12 districts and all health facilities	OR
PN4273	Planned Parenthood Association of Zambia	• Lusaka and Western province	OR
PN6946	Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS)	• Lusaka, Western and Central province • Health facilities	OR
ADOLESCENTS AND YOUTHS			
Strategic Plan outcome: *Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health*			
Country programme output: *Increased capacities of national, provincial and district institutions to design, implement and monitor comprehensive sexuality education programmes that promote human rights and gender equality*			
PGZM11	Ministry of Health - HQ	• National	RR, OR

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PGZM15	Provincial Health Office - North Western Province	• Solwezi, Mufumbwe, Chavuma, Zambezi district health offices • UNFPA model sites - Kashima (Mufumbwe), Chilenga (Zambezi) and Chiyeke (Chavuma) rural health centers • Other health facilities	RR, OR
PGZM16	Provincial Health Office - Luapula Province	• Mansa, Milenge, Samfya and Nchelenge (humanitarian) district health offices • Mansa General Hospital • Mantapala Refugee Re-settlement Center • UNFPA model sites - East 7 (Milenge) and Kasanka (Samfya) • Other health facilities in Milenge district (Kapalala, Sokontwe, Mulumbi, Lwela, Kabange, Chibende) • Other health facilities in Samfya district (Shikamushile, Katanshya, Miponda, Fwaka, Mushili rural health centers)	RR, OR
PGZM17	Provincial Health Office - Western Province	• 16 districts and all health facilities • UNFPA focus districts (Kalabo, Kaoma and Lukulu) • UNFPA model sites - Wenela (kalabo), Mulamba (Kaoma) and Lubosi (Lukulu) rural health centers	RR, OR
PGZM31	Provincial Health Office - Central Province	• 12 districts and all health facilities	OR
PN6553	Population Council	• Solwezi district	OR
PGZM20	Ministry of Youth, Sports and Child Development	• National	RR, OR
PN6493	Young Women's Christian Association	• Lusaka, North Western province	OR
PN6946	Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS)	• Lusaka, Western and Central province • Health facilities	OR
Country programme output: *Increased capacity of national, provincial and district institutions to design and implement comprehensive programmes for marginalized adolescent girls, including safe spaces, for those at risk of child marriage*			
PGZM29	Ministry of Chiefs and Traditional Affairs	• Western, Luapula and North Western province	RR, OR
PN6493	Young Women's Christian Association	• Lusaka, North Western, Luapula, Eastern (Katete district) and Western (Senanga) province	OR

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ATLAS PROJECTS (2016-2019)						2016			2017			2018			Mid-2019		
IA Code	**Implementing Partner**	**Geographic Location**	**Fund**	**Outcomes/Strategic Area**	**Outputs**	**Budget (KK)**	**Budget Utilization**	**Budget Utilization Rate**	**Budget (KK)**	**Budget Utilization**	**Budget Utilization Rate**	**Budget (KK)**	**Budget Utilization**	**Budget Utilization Rate**	**Budget (KK)**	**Budget Utilization**	**Budget Utilization Rate**
PGZM11	Ministry of Health - HQ	National	RR, OR	1. Sexual and reproductive health 2. Adolescents and youth	1. Integrated SRH, HIV and GBV services 2. Supply and demand for reproductive health commodities and medicines 3. Comprehensive sexuality education programmes	488,281.05	432,632.04	88.60	177,534.43	141,839.02	79.89	412,500.86	295,914.16	71.74	320,222.52	262,332.79	81.92
PGZM15	Provincial Health Office - North Western Province	Solwezi, Mufumbwe, Chavuma, Zambezi district health offices UNFPA model sites - Kashima (Mufumbwe), Chilenga (Zambezi) and Chiyeke (Chavuma) rural health centers Other health facilities	RR, OR	1. Sexual and reproductive health 2. Adolescents and youth	1. Integrated SRH, HIV and GBV services 2. Supply and demand for reproductive health commodities and medicines 3. Comprehensive sexuality education programmes 4. Programmes for marginalized adolescent girls	428,953.50	363,262.87	84.69	254,311.55	250,201.32	98.38	217,531.66	206,205.98	94.79	189,000.00	145,958.26	77.23
PGZM16	Provincial Health Office - Luapula Province	Mansa, Milenge, Samfya and Nchelenge district health offices Mansa General Hospital UNFPA model sites - East 7 (Milenge) and Kasanka (Samfya) Other health facilities in Milenge district (Kapalala, Sokontwe, Mulumbi, Lwela, Kabange, Chibende) Other health facilities in Samfya district (Shikamushile, Katanshya, Miponda, Fwaka, Mushili rural health centers)	RR, OR	1. Sexual and reproductive health 2. Adolescents and youth	1. Integrated SRH, HIV and GBV services 2. Supply and demand for reproductive health commodities and medicines 3. Comprehensive sexuality education programmes 4. Programmes for marginalized adolescent girls	146,468.04	138,552.50	94.60	224,656.10	211,094.12	93.96	212,106.03	190,557.87	89.84	232,687.88	211,194.14	90.76
PGZM17	Provincial Health Office - Western Province	16 districts and all health facilities UNFPA focus districts (Kalabo, Kaoma and Lukulu) UNFPA model sites - Wenela (kalabo), Mulamba (Kaoma) and Lubosi (Lukulu) rural health centers	RR, OR	1. Sexual and reproductive health 2. Adolescents and youth	1. Integrated SRH, HIV and GBV services 2. Supply and demand for reproductive health commodities and medicines 3. Comprehensive sexuality education programmes 4. Programmes for marginalized adolescent girls	195,478.48	138,385.69	70.79	276,318.92	270,175.73	97.78	1,234,731.57	1,092,052.78	88.44	313,824.00	94,884.00	30.23
PGZM19	Central Statistical Office	National	RR, OR	3. Population dynamics	5. Data generation and in-depth analysis of population dynamics	78,268.02	78,202.06	99.92	5,030.68	5,030.68	100.00	193,597.15	193,597.15	100.00	171,730.00	169,489.81	98.70
PGZM20	Ministry of Youth, Sports and Child Development	National	RR, OR	2. Adolescents and youth	3. Comprehensive sexuality education programmes	109,230.00	107,353.05	98.28	55,000.00	47,324.75	86.05				40,073.00	23,059.26	57.54
PGZM29	Ministry of Chiefs and Traditional Affairs	National Western, Luapula and North Western province	RR, OR	2. Adolescents and youth	3. Comprehensive sexuality education programmes 4. Programmes for marginalized adolescent girls	45,239.13	16,914.34	37.39	62,206.52	46,062.81					57,000.00	13,188.00	23.14
PGZM31	Provincial Health Office - Central Province	12 districts and all health facilities	OR	1. Sexual and reproductive health 2. Adolescents and youth	1. Integrated SRH, HIV and GBV services 2. Supply and demand for reproductive health commodities and medicines 3. Comprehensive sexuality education programmes	1,399,592.26	1,366,537.71	97.64	3,402.23	(3,418.44)	(100.48)	1,089,992.15	962,655.17	88.32	161,411.02	124,559.19	77.17

Final

ATLAS PROJECTS (2016-2019)						2016			2017			2018			Mid-2019		
IA Code	**Implementing Partner**	**Geographic Location**	**Fund**	**Outcomes/Strategic Area**	**Outputs**	**Budget (KK)**	**Budget Utilization**	**Budget Utilization Rate**	**Budget (KK)**	**Budget Utilization**	**Budget Utilization Rate**	**Budget (KK)**	**Budget Utilization**	**Budget Utilization Rate**	**Budget (KK)**	**Budget Utilization**	**Budget Utilization Rate**
PGZM32	Ministry of National Development Planning	National	RR, OR	3. Population dynamics	5. Data generation and in-depth analysis of population dynamics				2,580.00	2,568.05	99.54				63,000.00	23,562.00	37.40
PN4273	Planned Parenthood Association of Zambia	Lusaka and Western province	OR	1. Sexual and reproductive health	1. Integrated SRH, HIV and GBV services 2. Supply and demand for reproductive health commodities and medicines	419,184.87	391,088.66	93.30	470,457.18	419,637.03	89.20	433,043.29	381,881.47	88.19	88,242.89	78,054.72	88.45
PN6493	Young Women's Christian Association	Lusaka, North Western province	OR	2. Adolescents and youth	3. Comprehensive sexuality education programmes 4. Programmes for marginalized adolescent girls	474,844.61	463,397.96	97.59	661,202.86	641,000.98	96.94	499,551.11	427,116.45	85.50	380,077.83	282,169.84	74.24
PN6553	Population Council	National North Western	RR, OR	1. Sexual and reproductive health 2. Adolescents and youth 3. Population dynamics	1. Integrated SRH, HIV and GBV services 2. Supply and demand for reproductive health commodities and medicines 3. Comprehensive sexuality education programmes 4. Programmes for marginalized adolescent girls	472,798.00	469,343.00	99.27	65,473.93	34,642.00	52.91	412,363.44	410,110.57	99.45	232,790.00	170,889.16	73.41
PN6946	Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS)	Lusaka, Western and Central province 20 health facilities	OR	1. Sexual and reproductive health	1. Integrated SRH, HIV and GBV services 3. Comprehensive sexuality education programmes							367,919.00	198,661.57	54.00	326,109.20	137,450.74	42.15
PU0074	UN POPULATION FUND	National and all seven focus provinces (includes management/administration of the CO)	RR, OR	MANAGEMENT 1. Sexual and reproductive health 2. Adolescents and youth 3. Population dynamics	ORGANIZATIONAL EFFECIENCY AND EFFECTIVENESS 1. Integrated SRH, HIV and GBV services 2. Supply and demand for reproductive health commodities and medicines 3. Comprehensive sexuality education programmes 4. Programmes for marginalized adolescent girls	7,792,062.87	7,300,278.11	94.00	6,703,122.58	6,326,396.12	94.38	5,819,961.62	5,411,020.77	92.97	6,777,603.32	6,197,658.78	91.44

Final

Annex 5: Evaluation Matrix

EQ1: RELEVANCE

a) To what extent is the country programme aligned to the goals of the ICPD Programme of Action, SDGs and the strategies of UNFPA, and adapted to national needs, policies and development plans; priorities of the programme stakeholders and priority groups, particularly the vulnerable and marginalised (such as young people with disabilities)?

b) To what extent has the country office been able to respond to changes in national and provincial needs and priorities or to shifts caused by major political or humanitarian change? What was the quality of the response, particularly in relation to vulnerable and marginalised populations?

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for data collection collection
Assumption 1: The CP is aligned with national needs, priorities and policies, ICPD, SDGs and the core strategy of UNFPA; and particularly takes into account the needs of vulnerable populations.	• CP and AWPs reflect ICPD, and SDG goals and the core strategy of UNFPA • Evidence of systematic identification of the country's needs prior to the programming of each thematic component of the CP. • The extent to which UNFPA CO has appropriately taken into account the priorities of the Zambia Government and key stakeholders. • Choice of beneficiaries for UNFPA- supported interventions are consistent with identified needs as well as national priorities in the AWPs, including women, youth and other vulnerable groups • The CP contributes to building national capacities	• ICPD POA, SDG reports, UNFPA Strategic Plans 2014-2017, 2018 - 2021, 8CPD, AWPs, COARs, Zambia-UN Sustainable Development Partnership, Zambia Country Analysis • National policies, strategy and guideline documents (e.g. 7NDP, Adolescent Health Strategy, National Guidelines for SRH, HIV, GBV Services Integration, National AIDS Strategic Framework) • Zambia Constitution • Key informant interviews • Beneficiary FGIs	• Document analysis • Interviews with UNFPA CO staff, GRZ staff national and provincial • Focus Group Interviews (FGIs) with primary and secondary beneficiaries

Assumption 2: The CO has been able to respond adequately to shifts in the national context with a quality response.	• The speed and timeliness of response (response capacity) • Adequacy of the response (quality of the response) • Evidence of changes in programme design or interventions reflecting changes in needs of the population and priorities of GRZ, key stakeholders and beneficiaries	• AWPs, COARs • Project evaluation reports • Implementing Partners (IP) APRs • CO staff • UNCT • GRZ, key stakeholders and beneficiaries	• Document analysis • Interviews with CO staff, IPs, UN agencies, GRZ, donors • FGIs as appropriate

EQ2: EFFECTIVENESS

a) To what extent did the interventions supported by UNFPA in all programmatic areas contribute to the achievement of planned results (outputs and outcomes)? Were the planned geographical areas and priority populations successfully reached in terms of coverage and quality of programmes?

b) To what extent has the programme mainstreamed gender and human rights-based approaches including for people with disabilities?

c) To what extent did UNFPA contribute effectively to data generation and sustained increase in the use of disaggregated and evidence-based demographic and socio-economic data in policies, planning and programming?

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for data collection collection
Assumption 1: The UNFPA CP planned outputs were successfully achieved and contributed to the outcome results across all thematic areas, with a robust theory of change underlying the results chain logic	• Extent to which M&E of programmes and projects indicate the achievements of outputs • The extent to which outputs in the CP and Results and Resources Framework are likely to have contributed to outcome results through a robust theory of change	• M&E documentation • AWPs and APRs • Relevant programme, project and institutional reports • CO staff • GRZ, IPs and beneficiaries • Site visits	• Document analysis • Interviews with CO staff • Interviews with GRZ, IPs • FGIs with beneficiaries • Observation of facilities

Assumption 2: The cross-cutting issues of gender, disability and a human rights-based approach are evident in the implementation of the CP	• Evidence of increased incorporation during the 8CP of gender and a human rights approach in national policies, strategies and plans at national and sub-national levels developed during this period, and in IP programmes and projects • Evidence of the integration of gender, disability and a human rights-based approach within the planning, programme and project documents of UNFPA • Evidence of the integration of gender, disability and a human rights-based approach provided by KIs and beneficiaries	• Key government policies, strategies and plans at national and sub-national levels • IP progress reports, evaluations and reviews • AWPs and APRs • GRZ and key partners • CO staff • Beneficiaries	• Document analysis • Interviews with CO staff, GRZ and key stakeholders • FGIs with beneficiaries
Assumption 3: UNFPA contributed effectively to data generation and sustained increase in the use of disaggregated and evidence-based demographic and socio-economic data in policies, planning and programming	• Evidence of UNFPA support for data generation • Evidence of UNFPA support for increased dissemination and use of data in policies, planning and programming at national and sub-national levels • Evidence of geo-referencing	• Key government policies, strategies and plans at national and sub-national levels • AWPs, APRs • CO staff , GRZ, IPs • GRZ and key stakeholders	• Document analysis • Interviews with CO staff, GRZ and key stakeholders
EQ3: EFFICIENCY **a) To what extent has UNFPA made good use of its human, financial, administrative and technical and used an appropriate combination of tools and approaches to pursue the achievement of the outputs and outcomes defined in the country programme?** **b) To what extent are results effectively and efficiently measured and contributing to accountability in programming?**			
Assumptions to be assessed	**Indicators**	**Sources of information**	**Methods and tools for data collection collection**
Assumption 1: Implementing partners received UNFPA financial and technical support as planned and in a timely manner	• Financial resources were received to the level planned and in a timely manner • Quality technical assistance to build capacity was available to the level planned	• AWPs and APRs • CO financial reports • CO and IP staff • GRZ and key partners	• Document analysis • Interviews with CO staff, GRZ and IPs • FGIs with beneficiaries

Assumption 2: The UNFPA CO had adequate, qualified human resources and an efficient management structure and procedures	• CO organogram and changes over time • Management structure and procedures	• Organogram for UNFPA • Office reports • CO staff	• Document analysis • Interviews with CO staff
Assumption 3: Administrative, procurement and financial procedures and implementation modalities allow for efficient implementation of programme activities	• Appropriateness of UNFPA administrative, procurement and financial procedures • Appropriateness of IP selection criteria • Evidence of successful capacity building initiatives with partners	• AWPs and APRs • CO staff • GRZ, IPs and key partners • Beneficiaries	• Document analysis • Interviews with CO staff, GRZ, IPs and key partners • Beneficiary FGIs
Assumption 4: Robust M&E systems are in place and efficiently utilised	• Evidence of M&E system and documentation	• CO Programme Planning and Monitoring Matrix • COARs	• Document review • CO staff interview

EQ4: SUSTAINABILITY

a) **To what extent have UNFPA and its partners successfully promoted the national ownership of supported interventions, programmes and policies?**

b) **To what extent has UNFPA been able to develop implementing partner and beneficiary capacity, and established mechanisms to ensure ownership and the durability of effects?**

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for data collection collection
Assumption 1: National ownership regarding the UNFPA programme areas and integrated planning and programming have been strengthened, including for generation, dissemination and utilisation of disaggregated data	• How far GRZ contributes greater funds to UNFPA programme areas • How far GRZ has increased technical capacity in UNFPA programme areas • Evidence of increased programme integration in GRZ policies and plans • Disaggregated data are readily available at national and sub-national levels • Stakeholders effectively utilise data	• AWPs, COARs and APRs • GRZ policies and plans • CO staff • GRZ	• Document analysis • Interviews with CO staff, GRZ

<table>
<tr><td>Assumption 2: UNFPA partners have the technical capacity and the resources to contribute effectively to UNFPA supported interventions in all programme areas, in their policies, programmes and budgets</td><td>• Evidence of policies, programmes and budgets necessary to support continuity of programme results
• Evidence of ongoing benefits after the interventions have ended</td><td>• AWPs, APRs
• Programme and project evaluations
• CO staff
• Key partners
• Beneficiaries</td><td>• Document analysis
• Interviews with CO staff and key partners
• FGIs with beneficiaries</td></tr>
<tr><td>Assumption 3: UNFPA programme beneficiaries have increased knowledge and capacity regarding SRHR, HIV and GBV and greater access to and uptake of quality services</td><td>• Evidence in planning documents and reports of knowledge and capacity building efforts in beneficiaries
• Evidence of expanded and integrated high quality services for SRHR, HIV and GBV at all levels established and sustainable</td><td>• Policy briefs
• Constituency profiles
• IP AWPs and ARPs
• GZR and key partners</td><td>• Document review
• CO, GRZ and IP interviews
• Beneficiary FGIs</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4">EQ5: COORDINATION
a) To what extent has the UNFPA Country Office contributed to the functioning and consolidation of UNCT coordination and to Delivering as One (DaO), including with regards areas of potential overlap while maintaining its mandate?
b) To what extent does the Zambia-UN Sustainable Development Partnership Framework 2016-2021 reflect UNFPA priorities and mandate in the pillars, indicators and targets?</td></tr>
<tr><th>Assumptions to be assessed</th><th>Indicators</th><th>Sources of information</th><th>Methods and tools for data collection</th></tr>
<tr><td>Assumption 1: UNFPA CO has contributed effectively to UNCT coordination and to DaO including in areas of potential overlap and with cross-cutting issues of gender, disability and human rights-based programming</td><td>• Evidence of UNFPA active participation in UNCT and in technical working groups
• Mechanisms are in place for coordination of areas of potential overlap, including with regards cross-cutting issues
• Evidence of joint programming</td><td>• Joint programme reports, reviews and evaluations
• CO staff, UNCT, UN programme officers</td><td>• Interviews with CO staff, UNCT, UN programme officers
• Document analysis</td></tr>
<tr><td>Assumption 2: the Zambia-UN SDPF 2016-2021 sufficiently reflects the priorities and mandate of UNFPA</td><td>• Zambia-UN SDPF 2016-2021 and MTR indicators aligned with UNFPA mandate, priorities and indicators</td><td>• Zambia-UN SDPF 2016-2021 and MTR
• CO staff, UN partners</td><td>• Document review
• Interviews with CO staff, UN partners</td></tr>
</table>

Annex 6: Main Tools

Tool 1

Key informant interview guide for CPE: GRZ, IPs PD/SRH/A&Y

Interviewer:...Interview #.........................…...Date.............

Interviewee(s) Name(s):...

Organisation …………………..................................Location …………………........

Position(s) ………………………………………………………………………........

Semi-structured interview schedule with lead question areas to be adapted and probed according to KI and component area and focus of interview. Indicate overarching focus of CP and CPE, relating to SRH, A&Y and PD, and to questions of relevance, effectiveness, efficiency, sustainability and coordination, with cross-cutting issues of gender, human rights, disability.

Introduce self and purpose of interview, thank for time commitment. Assure re confidentiality.

Indicate overarching focus (for orientation only):

SRH: UNFPA support to increase capacity of national, provincial and district institutions to deliver gender-sensitive sexual and reproductive health and HIV services including improved supply of SRH commodities, as well as increasing demand for commodities and services.

A&Y: UNFPA support to increase capacity of regarding comprehensive sexuality education and comprehensive programmes for marginalized adolescent girls including safe spaces for those at risk of child marriage.

PD: UNFPA support to data generation and utilisation of disaggregated demographic and socio-economic data in evidence-based planning and development at national and sub-national levels from in-depth analysis of population dynamics, sexual and reproductive health, HIV, and gender equity.

1. What is the main function of the IP/GRZ department/other partner?

2. How does UNFPA contribute to this function? (probe re finance/ TA/ capacity building etc. over time)

3. Questions elaborated from the Evaluation Matrix. Probe as needed and relevant to IPs/GRZ/other partners with respect to evaluation criteria: (indicative questions from which to select)

Probe re focus on gender, disability and human rights as appropriate

Relevance, responsiveness

1. The relevance of UNFPA support. Probe, including possible gaps
2. How far UNFPA was able to respond to changing needs of the IP/partner/ context. Probe

Effectiveness

1. Sufficiency of UNFPA contribution to the GRZ/IP/Partner to achievement of planned programme results, and identification of any gaps or challenges. Probe
2. UNFPA support for challenges in the implementation of interventions to address outputs and outcomes.
3. UNFPA responsiveness to challenges in M&E etc. Probe
4. Timeliness of dispersal of UNFPA funds. Probe re any challenges
5. UNFPA support for programme integration of gender and a human-rights approach, including people with disabilities
6. UNFPA support for use of disaggregated demographic and socio-economic data for evidence-based planning and development.

Efficiency

1. Expenditure of UNFPA funding. Probe
2. Monitoring and evaluation systems in place and reporting by IP. Probe

Final

Sustainability

1. Likelihood of continued UNFPA support. Probe re what support is most needed
2. Measures in place for programme continuity in the absence of continued UNFPA support. Probe e.g. re output/outcome areas integrated in institutional/government policies and plans
3. Other sources of technical and financial support. Probe
4. Likelihood of sustained benefits (e.g. through capacity building, improved M&E and other systems, population data availability, etc. with or without continued UNFPA support). Probe

BRIEF SWOT re UNFPA contributions, if useful and appropriate: Strengths, Weaknesses/limitations, Opportunities, Threats

Invite further questions as appropriate, thank KI and reassure re confidentiality.

(Adapt tool to specific type of partner and focus)

Tool 2:

Key informant interview schedule for UNCT and UNFPA CR

Interviewer **Interview #** **Date**

Interviewee name(s) **Organisation**

Semi-structured interview schedule with lead question areas in which to probe.

Introduce self and purpose of interview, thank interviewee(s) for time commitment. Assure confidentiality.

Indicate overarching focus of CP and CPE, relating to SRH, A&Y and PD, and to questions of relevance, effectiveness, efficiency, sustainability and coordination, with cross-cutting issues of gender, human rights, disability.

EQ5: COORDINATION to address (state A and B):

A) To what extent has the UNFPA Country Office contributed to the functioning and consolidation of UNCT coordination, including with regards areas of potential overlap while maintaining its mandate? Probe re:

1. How active, relevant and effective is UNFPA in UNCT?

2. How does UNFPA contribute to UNCT coordination? Any particular responsibilities?

3. Where there are areas of potential overlap with other UN mandates, how is this resolved? (e.g. re gender, disability, human-rights based programming, response in humanitarian situations as well as main focal areas of SRH, A&Y, PD

B) How and to what extent are UNFPA priorities and mandate reflected in the Zambia-UN Sustainable Development Partnership Framework 2016-2021? Probe

BRIEF SWOT re UNFPA contributions if useful and appropriate:

Strengths, Weaknesses/limitations. Opportunities, Threats

Any further questions/probes

Thank again for time and seek potential for further brief questions if required during CPE

Tool 2:

Key informant interview schedule for UNCT and UNFPA CR

Interviewer **Interview #** **Date**

Interviewee name(s) **Organisation**

Final

Semi-structured interview schedule with lead question areas in which to probe.

Introduce self and purpose of interview, thank interviewee(s) for time commitment. Assure confidentiality.

Indicate overarching focus of CPE, relating to PD, SRH and A&Y and to questions of relevance, effectiveness, efficiency, sustainability and coordination, with cross-cutting issues of gender, human rights, disability.

EQ5: COORDINATION to address (state A and B):

C) To what extent has the UNFPA Country Office contributed to the functioning and consolidation of UNCT coordination, including with regards areas of potential overlap while maintaining its mandate? Probe re:

4. How active, relevant and effective is UNFPA in UNCT?

5. How does UNFPA contribute to UNCT coordination? Any particular responsibilities?

6. Where there are areas of potential overlap with other UN mandates, how is this resolved? (e.g. re gender, disability, human-rights based programming, response in humanitarian situations as well as main focal areas of SRH, A&Y, PD

D) How and to what extent are UNFPA priorities and mandate reflected in the Zambia-UN Sustainable Development Partnership Framework 2016-2021? Probe

BRIEF SWOT re UNFPA contributions if useful and appropriate:

Strengths, Weaknesses/limitations. Opportunities, Threats

Any further questions/probes

Thank again for time and seek potential for further brief questions if required during CPE

Tool 2:

Key informant interview schedule for UNCT and UNFPA Country Representative

Interviewer **Interview #** **Date**

Interviewee name(s) **Organisation**

Semi-structured interview schedule with lead question areas in which to probe.

Introduce self and purpose of interview, thank interviewee(s) for time commitment. Assure confidentiality.

Indicate overarching focus of CP and CPE, relating to SRH, A&Y and PD to questions of relevance, effectiveness, efficiency, sustainability and coordination, with cross-cutting issues of gender, human rights, disability.

EQ5: COORDINATION to address (state A and B):

E) To what extent has the UNFPA Country Office contributed to the functioning and consolidation of UNCT coordination, including with regards areas of potential overlap while maintaining its mandate? Probe re:

7. How active, relevant and effective is UNFPA in UNCT?

8. How does UNFPA contribute to UNCT coordination? Any particular responsibilities?

9. Where there are areas of potential overlap with other UN mandates, how is this resolved? (e.g. re gender, disability, human-rights based programming, response in humanitarian situations as well as main focal areas of SRH, A&Y, PD

F) How and to what extent are UNFPA priorities and mandate reflected in the Zambia-UN Sustainable Development Partnership Framework 2016-2021? Probe

BRIEF SWOT re UNFPA contributions if useful and appropriate:

Strengths, Weaknesses/limitations. Opportunities, Threats

Any further questions/probes

Thank again for time and seek potential for further brief questions if required during CPE

Tool 3

FGI Guide (training) Project/location:.....................FGI # ....Date:................

Interviewer:.............................Beneficiaries:..................................Number/Sex:.......................…

Introduce self and purpose of group interview, thank participants for their time commitment. Assure confidentiality.
Indicate overarching focus of CP and CPE, relating to SRH, A&Y and PD and to questions of relevance, effectiveness, efficiency, sustainability and coordination, with cross-cutting issues of gender, human rights, disability as appropriate to group.
Invite any initial queries, points for clarification.

1. Probe re the training received/what does/did it consist of etc. If training, when, how long, any follow up/quality assurance; role of UNFPA and others (if appropriate)
2. Probe re what made beneficiaries interested in becoming involved in (services, training, etc.) What were the problems they were facing? Relevance of benefit to their needs?
3. Probe re quality of benefits. What are the most important benefits / learning / other benefits?
4. Probe around what is being done differently after the service/training (re service provision/re behaviour change etc.). Are changes likely to be sustained/why/why not?
5. Probe re what aspects of the service/training did not work well
6. Suggestions for improvements
7. Further unmet needs (for services/ training etc. in relation to the thematic area)
8. Invite any final questions or comments

Thank all participants again, and reconfirm confidentiality.

Tool 4

FGIs Primary Beneficiaries: Young people, women/men at SRH/GBV/HIV integrated services

FGI #..Date:................

Interviewer:.........Project/site/services:.......................…Beneficiary group (#, gender):....................
Similar tool for CSE for in and out of school youth, and another for parents and teachers, adapt for fistula clients

The session starts with introductions, purpose of the FGI, confirmation of confidentiality, thanking participants for their time. The guide provides broad indicative questions around which to probe. After the FGI the interviewer will undertake thematic and content analysis and summarise the main findings, and draw provisional conclusions and recommendations.
1) a) Please tell me the reasons why you come to the facility/centre. b) How has this facility/centre and its staff been sensitive and responsive to your needs? Probe re relevance, effectiveness, efficiency (e.g. re/waiting times for services/integration), reliability etc. and overall satisfaction with the facility/centre and staff. Probe re community outreach (SMAGs/CBDs/PEs as well as facility.
2) Are there any additional services or support that you would like to get from this facility/centre? Probe re gaps; probe re ease of access, opening times, barriers to access.

Final

3) How responsive do you find the staff to your needs? Are there issues that you find difficult to discuss? Probe why staff may find it difficult to respond or beneficiaries find it difficult to raise issues (e.g. re privacy, judgemental values, embarrassment, confidentiality, gender insensitivity or insensitivity to youth needs etc.).
4) If it were possible to make any changes at the facility/centre, what changes would you like to see?
5) Would you recommend others to come for ANC and facility delivery/ regarding take up of FP?   Explore reasons
6) Any final questions or comments that you would like to add?
Thank everyone for their time and participation, and repeat re confidentiality

Final

Annex 7: Documented Achievements in Zambia against SDGs

Sustainable Development Goals (SDGs) Status	Indicator and source	Status
Goal 2. End hunger, achieve food security and improved nutrition, and promote sustainable agriculture	Proportion of children under 5 years who are underweight (ZDHS 2018)	12%
	Proportion of under 5 years severely underweight (ZDHS 2018)	2.3%
Goal 3. Ensure healthy lives and promote well-being for all at all ages	Maternal mortality ratio (per 100,000 live births) (ZDHS 2018)	278
	Adolescent birth rate (aged 10-14 years) per 1,000 women in that age group	No data
	Adolescent birth rate (aged 15-19 years) per 1,000 women in that age group (%) (ZDHS 2018)	29.2%
	Births attended by skilled health personnel (ZDHS 2018)	80%
	Antenatal care coverage (ZDHS 2018)	97%
	Infant mortality rate (per 1,000 live births) (ZDHS 2018)	42
	Under 5 years mortality rate (per 1,000 live births) (ZDHS 2018)	61
	HIV prevalence among general population (ZAMPHIA 2016)	11.4%
	HIV prevalence among 15-24 year olds (ZAMPHIA 2016)	3.8%
	Level of comprehensive knowledge about HIV among 15-24 yr olds (ZDHS 2018)	40.6% male / 42.6% female
	Proportion of adult population infected with HIV accessing ARVs (UNAIDS 2017)[158]	Total 70%; Male 64%; Female 74%
	Number of new HIV infections per 1,000 uninfected population by sex, age and key populations (15-59 years) (ZAMPHIA 2016)	0.61% (43,000 annually)
	Proportion of children under 5 years who slept under ITN[159] (ZDHS 2018)	48.1%
	Proportion of pregnant women who slept under ITN (ZDHS 2018)	44.8%
	TB prevalence rate (per 100,000) (MoH TB 2013/14)[160]	319
	Contraceptive prevalence rate (ZDHS 2018)	48%
	Unmet need for family planning (ZDHS 2018)	20%
	Proportion of women of reproductive age (15-49 years) who have their need for family planning satisfied with modern methods (ZDHS 2018)	68.5%
Goal 4. Ensure inclusive and equitable quality education and promote life-long learning opportunities for all	Primary school net enrolment rate (NER) (MoGE 2017)[161]	87.9%
	Proportion of pupils completing primary school (MoGE 2017)	91.8%
	Primary to secondary transition rate (MoGE 2017)	67.5%
	Secondary school NER (MoGE 2017)	42.9%

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[158] UNAIDS 2017 - https://www.unaids.org/en/regionscountries/countries/zambia
[159] Insecticide Treated Mosquito Net
[160] Ministry of Health, National Tuberculosis Prevalence Survey 2013-2014
[161] Ministry of General Education, Educational Statistical Bulletin, 2017

	Ratio of girls to boys in primary school (MoGE 2017)	1.00
	Ratio of girls to boys in secondary school (MoGE 2017)	0.90
	Literacy rates of 15-24 years (ZDHS 2013/14)	Male 84.9%, Female 77.3%
	Literacy level among men aged between 15-49years (ZDHS 2013/14)	83%
	Literacy level among women aged between 15-49 years (ZDHS 2013/14)	67.5%
Goal 5. Achieve gender equality and empower all women and girls	Proportion of seats held by women in the National Assembly (National Assembly of Zambia 2019)[162]	18.2%
	Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by current or former intimate partner in the previous 12 months by form of violence and by age (ZDHS 2013/14)	47%
	Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence (ZDHS 2013/14)	10.4%
	Proportion of women aged 20-24 years who were married or in a union before age 15 (ZDHS 2013/14)	5.9%
	Proportion of women aged 20-24 years who were married or in a union before age 18 (ZDHS 2013/14)	31.4%
Goal 7. Ensure access to affordable, reliable, sustainable, and modern energy for all	Proportion of electricity generated from renewable sources	-
Goal 8. Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all	Annual GDP Growth	3.7%
	Mobile money subscriptions	-
Goal 9. Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation	Mobile penetration rate (World Bank 2017)[163]	78.6%
	Internet / data penetration rate (World Bank 2017)[164]	27.9%
Goal 16. Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels	Proportion of children under 5 years of age whose births have been registered with a civil authority, by age 3 (ZDHS 2013/14)	11.3%

[162] National Assembly of Zambia - http://www.parliament.gov.zm/members/gender
[163] World Bank - https://data.worldbank.org/indicator/IT.CEL.SETS.P2?locations=ZM
[164] World Bank - https://data.worldbank.org/indicator/IT.NET.USER.ZS?locations=ZM

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Annex 8: The Stakeholder Map and Stakeholder Consultation Process

The Stakeholder Map

Donors	Implementing Agencies	Other partners	Beneficiaries
POPULATION DYNAMICS			
Strategic Plan outcome: *Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality*			
Country programme output: *Increased availability of disaggregated evidence through cutting-edge data generation and in-depth analysis of population dynamics, sexual and reproductive health, HIV, and gender-equality outcomes*			
• UNFPA • DFID • Gates Foundation	• Ministry of National Development Planning • Central Statistical Office • Population Council	• UNDP • UNICEF • Surveyor General • University of Zambia	• National, Provincial and District Planning and CSO units
SEXUAL REPRODUCTIVE HEALTH AND RIGHTS			
Strategic Plan outcome: *Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access*			
Country programme output: *National, provincial and district institutions have increased capacity to deliver gender-sensitive sexual and reproductive health and HIV services*			
• DFID • UNFPA • SIDA • European Union • UNPRPD Disability Fund • Maternal Health Thematic Fund • CERF	• Ministry of Health - HQ • Provincial Health Office - Luapula Province • Provincial Health Office - North Western Province • Provincial Health Office - Western Province • Provincial Health Office - Central Province • PPAZ • SAfAIDS	• District Health Offices • National Assembly • Systems for Better Health • Fistula Foundation • Marie Stopes International • Centre for Reproductive Health and Education • National AIDS Council • ILO	• Health facilities • Health care workers • Safe Motherhood Action Groups • Peer educators • Women, men, boys and girls
Country programme output: *National, provincial and district institutions have the capacity to increase demand for and improve supply of life-saving reproductive health commodities and medicines, including modern contraceptives*			

<table>
<tr><th>Donors</th><th>Implementing Agencies</th><th>Other partners</th><th>Beneficiaries</th></tr>
<tr><td>• DFID
• UNFPA</td><td>• Ministry of Health - HQ
• Provincial Health Office - Luapula Province
• Provincial Health Office - North Western Province
• Provincial Health Office - Western Province
• Provincial Health Office - Central Province
• PPAZ</td><td>• District Health Offices
• Medical Stores Limited
• Abt Associates
• National Assembly
• Marie Stopes International</td><td>• Health facilities
• Health care workers
• Community based distributors
• Peer educators
• Women, men, boys and girls</td></tr>
<tr><td colspan="4">ADOLESCENTS AND YOUTHS</td></tr>
<tr><td colspan="4">Strategic Plan outcome: Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health</td></tr>
<tr><td colspan="4">Country programme output: Increased capacities of national, provincial and district institutions to design, implement and monitor comprehensive sexuality education programmes that promote human rights and gender equality</td></tr>
<tr><td>• UNFPA
• DFID
• SIDA
• SDC</td><td>• Ministry of Health - HQ
• Provincial Health Office - Luapula Province
• Provincial Health Office - North Western Province
• Provincial Health Office - Western Province
• Provincial Health Office - Central Province
• Ministry of Youth, Sports and Child Development
• Population Council
• SAfAIDS</td><td>• Ministry of General Education
• UNESCO
• National Assembly
• National AIDS Council</td><td>• Health facilities
• Health care workers
• Peer educators
• Community based organizations
• Teachers
• Women, men, boys and girls</td></tr>
<tr><td colspan="4">Country programme output: Increased capacity of national, provincial and district institutions to design and implement comprehensive programmes for marginalized adolescent girls, including safe spaces, for those at risk of child marriage</td></tr>
</table>

Donors	Implementing Agencies	Other partners	Beneficiaries
• DFID • Canada • UNFPA	• Ministry of Chiefs and Traditional Affairs • Young Women's Christian Association • Senanga District - Western Province • Katete District - Eastern Province • Provincial Health Office - Luapula Province • Provincial Health Office - North Western Province	• Ministry of General Education • House of Chiefs • National Assembly • Chief's Spouses	• Adolescent girls and body • Mentors • Community based organizations

Stakeholder Consultation Process

Wide stakeholder consultation was undertaken during all phases of the evaluation: (i) preparation; (ii) design; (iii) field; (iv) analysis and reporting; and (v) facilitation of use and dissemination phase.

1. ***Preparatory Phase:*** *C*onstitution and establishment of the Evaluation Reference Group (ERG) comprising representatives from implementing partners, key line ministries, civil society organizations, youth organizations, UN agencies, academia, and selected UNFPA Country Office (CO) staff (see list below). The ERG was tasked to provide constructive guidance and feedback on the implementation and products of the evaluation, hence contributing to both the quality and compliance of this exercise. The ERG was coordinated by the Population and Development Department of the Ministry of National Development Planning (MNDP) in close liaison with UNFPA. The ERG reviewed the evaluation Terms of Reference and provided constructive feedback. Pre-selection of the evaluation team and preparation of a stakeholder map from which sampling was made was undertaken jointly with MNDP.

2. ***Design Phase***: The Evaluation Manager, CO, MNDP and the ERG contributed to quality assessment of the design report and its annexes. The evaluation team proposed purposive sampling from the stakeholder map according to the Handbook criteria for selection (see 4.3); and developed the design report for approval by the ERG and CO. A consultative meeting was held during which the design report was presented to the ERG for review and approval. The evaluation team incorporated recommended amendments in the revised design report that informed the field phase of the evaluation.

3. ***Field Phase:*** The MNDP and the CO coordinated field work in close consultation with sampled stakeholders. The evaluation team: undertook field work with the agreed sample of stakeholders to collect primary data to address the evaluation questions (see Annex 2: Institutions and Persons Met):; conducted extensive secondary data (document) review; cleaned, triangulated and analysed data; identified any gaps in data and undertook follow up with stakeholders as needed; and provided a fieldwork debriefing to the CO, including overarching field work experience, findings and challenges faced.

4. ***Reporting Phase:*** The evaluation team undertook further analysis and drafting of a zero draft evaluation report for review by the CO. The revised report was submitted to the ***ERG for comments and further validated through a key stakeholders' meeting during which consultations on draft recommendation were undertaken***. A PowerPoint presentation was made at the validation meeting and the full report shared with an agreed timeline to provide feedback.

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The evaluation team incorporated further feedback in the final evaluation report. The Evaluation Manager and ESARO Monitoring and Evaluation Advisor completed the Evaluation Quality Assessment Grid of the final report.

5. ***Facilitation of Use and Dissemination Phase:*** The Evaluation Manager and Communications Analyst implement the communication plan to share the report. The Evaluation Manager presented key findings, conclusions and recommendations to implementing partners at the 2019 Annual Review and 2020 planning meeting held in November. This informed the prioritization of strategic interventions to be implemented in 2020 as learned from the evaluation. The findings were also used to inform the initiation of the extension process of the current Country Programme to 2021.

List of ERG Members

Implementing Partners

1. Ministry of National Development Planning
2. Ministry of Health (National and Provincial)
3. Ministry of Chiefs and Traditional Affairs
4. Ministry of Youth, Sports and Child Development
5. Central Statistical Office
6. Population Council
7. Planned Parenthood Association of Zambia (PPAZ)
8. Young Women's Christian Association (YWCA)
9. Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS)

Other Key Line Ministries

10. Ministry of Gender
11. Minister of General Education
12. Ministry of Higher Education

Other Civil Society Organizations

13. Centre for Reproductive Health

Youth Organizations

14. Network of Youth in Population and Development

UN Agencies

15. UNICEF
16. WHO
17. UNAIDS
18. UNDP

Academia

19. University of Zambia - Population Studies Department

UNFPA CO staff

20. Assistant Representative
21. M&E Analyst
22. Communications Analyst
23. Gender Analyst
24. Programme Specialist - Reproductive Health
25. Programme Specialist - ASRH & Youth

ESARO

26. Regional M&E Advisor

Final