Country Programme Evaluation of UNFPA Rwanda 8th Country Programme

Evaluation Report

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UNFPA IN RWANDA

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Disclaimer

The analysis and recommendations of this evaluation does not necessarily reflect the views of the United Nations Population Fund.

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Acronyms and abbreviations

ASRH	Adolescent Sexual and Reproductive Health
AWP	Annual Work Plan
AY	Adolescents and Youth
CO	Country Office
CP	Country Programme
CPE	Country Programme Evaluation
DRC	Democratic Republic of Congo
EmONC	Emergency Obstetric and Neonatal Care
ENABEL	Belgium Development Agency
EICV	Integrated Household Living Conditions Survey
EQA	Evaluation Quality Assessment
EQAA	Evaluation Quality Assurance and Assessment
ERG	Evaluation Reference Group
ESARO	East and South Africa Regional Office
FGD	Focus Group Discussion
FP	Family Planning
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GNI	Good Neighbours International
GoR	Government of Rwanda
HCT	Humanitarian Country Team
HDI	Human Development Index
HSSP	Health Sector Strategic Plan
IDI	In-depth interview
ICPD	International Conference on Population and Development
JICA	Japan International Cooperation Agency
KII	Key Informant Interviews
KOICA	Korean International Cooperation Agency
M&E	Monitoring and Evaluation
MINEMA	Ministry in charge of Emergency Management
MoH	Ministry of Health
NST	National Strategy for Transformation
OECD/DAC	Organization for Economic Cooperation and Development Development Assistance Committee
PWD	Person with Disabilities
RDHS	Rwanda Demographic and Health Survey
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SDC	Swiss Agency for Development and Cooperation
SDG	Sustainable Development Goal
SGBV	Sexual and Gender-Based Violence
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
TFR	Total Fertility Rate
ToC	Theory of Change
ToR	Terms of Reference
TVET	Technical and Vocational Education and Training
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Plan
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNSDCF	United Nations Sustainable Development Cooperation Framework

Key facts table: Rwanda

Geography	
Geographical location	East Africa
Land area	26,338,000km^2
Politics	
Government type	Democratic Republic
Key political events	Commemoration of the 1994 Genocide against the Tutsi, Umushyikirano, Liberation Day, Heroes' Day, Umuganura
Economy	
GDP per capita[1]	822.2 USD
Health expenditure (as a % of GDP)[2]	7.32% (2020)
Gini index[3]	0.29
Demography	
Total Population[4]	13,246,394
Population growth rate[5]	2.3%
Life expectancy at birth, Male/Female (year)[6]	69.6; 67.7/71.2 years
Maternal mortality (death of women per 100,000 livebirths)[7]	203
Neonatal mortality (per 1000 live births)	19
Under-5 mortality (per 1000 live births)[8]	45
Urban/Rural population[9]	27.9% / 72.1%
Human Development Index[10]	0.534
Gender Inequality index[11]	0.81 (2022)
Young people	

[1] World Bank. Open Data, https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?locations=RW
[2] Ibid., https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=RW
[3] National Institute of Statistics of Rwanda (NISR), Ministry of Health (MOH), and ICF (2020). Rwanda Demographic and Health Survey 2019–20. Key Indicators Report. Kigali, Rwanda, and Rockville, Maryland, USA: NISR and ICF.
[4] National Institute of Statistics of Rwanda (NISR) (2023). The Fifth Rwanda Population and Housing Census, Main Indicators Report. Kigali: NISR
[5] Ibid.
[6] Ibid.
[7] National Institute of Statistics of Rwanda (NISR), Ministry of Health (MOH), and ICF (2020). Rwanda Demographic and Health Survey 2019–20. Key Indicators Report. Kigali, Rwanda, and Rockville, Maryland, USA: NISR and ICF.
[8] Ibid.
[9] National Institute of Statistics of Rwanda (NISR) (2023). The Fifth Rwanda Population and Housing Census, Main Indicators Report. Kigali: NISR
[10] World Bank Open Data, https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?locations=RW
[11] World Data Atlas. https://knoema.com/atlas/Rwanda

Male primary and secondary attendance (7–18 years)[12]	76.9%
Female primary and secondary attendance (7–18 years)[13]	80%
Proportion of population aged under 18 (0–17 years)[14]	44.5
Adolescent fertility rate[15]	2.6
Fertility	
Total fertility rate[16]	3.6
Contraceptive prevalence rate (modern methods) [17]	64%
Unmet need for family planning in currently married women (15–49 years)[18]	14%
Births attended by skilled personnel[19]	94%
HIV	
HIV prevalence rate, 15–49 years [20]	2.6%
HIV prevalence, 15–24 years: Male/Female (%)[21]	1.8/3.3
HIV incidence rural/urban[22]	0.07/0.12
HIV incidence for 15–49 years, Male/Female[23]	0.08,0.10/0.06
HIV incidence for 15–64 years, Male/Female[24]	0.08, 0.09/0.07
HIV stigma index[25]	15
HARMFUL PRACTICES	
Rates of child marriage[26]	7%

[12] National Institute of Statistics of Rwanda (NISR) (2023). The Fifth Rwanda Population and Housing Census, Main Indicators Report. Kigali: NISR
[13] Ibid.
[14] Ibid.
[15] Ibid.
[16] Ibid.
[17] National Institute of Statistics of Rwanda (NISR), Ministry of Health (MOH), and ICF (2020). Rwanda Demographic and Health Survey 2019–20. Key Indicators Report. Kigali, Rwanda, and Rockville, Maryland, USA: NISR and ICF.
[18] Ibid.
[19] Ibid.
[20] Rwanda Biomedical Center. Rwanda Population-Based HIV Impact Assessment 2018-2019: Final Report. September 2020. https://phia.icap.columbia.edu/wp-content/uploads/2020/11/RPHIA-Final-Report_Web.pdf

[21]Ibid.

[22] Ibid.
[23] Ibid.
[24] Ibid.
[25] KT Press. Stigma around HIV/AIDS on decline – RRP+ survey. https://www.ktpress.rw/2022/07/stigma-around-hiv-aids-on-decline-rrp-survey/
[26] Girls Not Brides. https://www.girlsnotbrides.org/learning-resources/child-marriage-atlas/regions-and-countries/rwanda/

Rate of gender-based violence[27]	36.7% of women and 30% of men aged 15–49

Sustainable Development Goals (SDGs) status	Indicators and source	Status
Goal 2. End hunger, achieve food security and improved nutrition and promote sustainable agriculture [28]	Proportion of children under 5 years who are underweight	8%
	Proportion of children under 5 years severely underweight	1%
Goal 3. Ensure healthy lives and promote well-being for all at all ages [29]	Maternal mortality ratio (per 100,000 live births)	203
	Birth attended by skilled health personnel	94.2
	Under 5 mortality rate (per 1,000 live births)	49
	Neonatal mortality rate	19
	Proportion of women (15–49 years) who have their need for family planning satisfied with modern methods	73.7
	Adolescent birth rates per 1,000 women (15–19)	32
Goal 5: Gender equality [30]	Proportion of ever-partnered women and girls aged 15 years and older subjected to physical violence	19.7
	Proportion of ever-partnered women and girls aged 15 years and older subjected to sexual violence	10.3
	Proportion of ever-partnered women and girls aged 15 years and older subjected psychological violence	23.6
	Proportion of women (20–24) years who were married or in a union before age 15	0.3
	Proportion of women (20–24) years who were married or in a union before age 18	5.5
	Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care	63.1
	Proportion of individuals who own a mobile telephone	54.8
Goal 7: Affordable clean energy [31]	Proportion of population with access to electricity	46.6
	Proportion of population with primary reliance on clean fuels and technology	3.6
Goal 8: Decent work and economic growth [32]	Proportion of adults (15 years and older) with an account at a bank or	28.8

[27] National Institute of Statistics of Rwanda (2021). National Gender Statistics Report 2021. https://statistics.gov.rw/publication/1850
[28] National Institute of Statistics of Rwanda (NISR), Ministry of Health (MOH), and ICF (2020). Rwanda Demographic and Health Survey 2019–20. Key Indicators Report. Kigali, Rwanda, and Rockville, Maryland, USA: NISR and ICF.
[29] Ibid.
[30] Ibid.
[31] Ibid.
[32] Ibid.

	other financial institution or with a mobile-money-service provider	
Goal 16: Peace, justice, and strong institutions [33]	Proportion of children under 5 years of age whose births have been registered with a civil authority	85.6
Goal 17: Partnerships for the goals [34]	Proportion of individuals using the Internet	17.6

[33] National Institute of Statistics of Rwanda (NISR), Ministry of Health (MOH), and ICF (2020). Rwanda Demographic and Health Survey 2019–20. Key Indicators Report. Kigali, Rwanda, and Rockville, Maryland, USA: NISR and ICF.
[34] Ibid.

Executive Summary

Purpose and scope of the evaluation

Intended Audience: This report presents the findings of an independent evaluation commissioned by UNFPA, the United Nations sexual and reproductive health agency, to evaluate the UNFPA 8th Country Programme for Rwanda 2018–2024. The evaluation was conducted from July to August 2023 and covered the programme implementation from 1 July 2018 to 30 June 2023. The UNFPA Country Programme for Rwanda is implemented in partnership with the Government of Rwanda. In 2018–2024, UNFPA's financial contribution to the programme amounted to US$16.2 million. The Country Programme (CP) covered three thematic areas: (i) sexual and reproductive health and rights; (ii) adolescents and youth; and (iii) population and development. The primary audience and users of the evaluation include the UNFPA Rwanda Country Office (CO), national partners, and relevant government and development agencies, who are each expected to benefit from the evaluation's findings, conclusions and recommendations. In addition, the United Nations agencies represented in the country will use the findings of this evaluation during the development of the next CP for Rwanda for 2024–2029.

Objectives and scope: The purpose of this Country Programme Evaluation (CPE) includes the following: (i) to demonstrate accountability to stakeholders on 8th Country Programme ("8th CP") performance in achieving development results and on invested resources; (ii) to support evidence-based decision-making; and (iii) to contribute key lessons learned to the existing knowledge base on how to accelerate the implementation of the Programme of Action of the 1994 International Conference on Population and Development (ICPD). The objectives of the CPE were: i) to provide the UNFPA Rwanda CO, national stakeholders and rights-holders, as well as a wider audience, with an independent assessment of the UNFPA Rwanda 8th CP (2018–2024); ii) to enhance the accountability of the UNFPA CO for the relevance and performance of the 8th CP; and iii) to broaden the evidence base to position UNFPA within the updating of the United Nations Common Country Analysis and the development of the United Nations Sustainable Development Cooperation Framework (UNSDCF), as well as to inform the design of the next programme cycle guided by the new UNSDCF. The evaluation is designed to assess the outputs against six criteria: relevance, efficiency, effectiveness, sustainability, coordination, and development-humanitarian connectedness. The evaluation is intended to help key stakeholders, including UNFPA Rwanda, to make reasonable choices regarding the approach towards interventions in the country and the components that should be maintained, modified, or added in the upcoming 9th Country Programme.

The evaluation covered interventions at both national and district levels where most UNFPA CO interventions were focused. The CPE assessed activities carried out from 1 July 2018 to 30 June 2023 in the three programmatic areas of sexual and reproductive health and rights (SRHR), adolescents and youth, and population dynamics, as well as in the cross-cutting areas of gender equality, human rights, resource mobilization and partnerships, communication, M&E, and innovation.

Methodology: The evaluation was conducted by a three-person team (a team leader and two national experts) in two phases: development of a design report, June to July 2023, and the evaluation carried out in Rwanda, July to August 2023. The evaluation is based on non-random samples of respondents with qualitative data collection methods. All interviews followed informed consent procedures as required by the United Nations ethics guidelines for evaluators. The collection of evaluation data was implemented using four main methods: 1) Desk review 2) Semi-structured group and individual interviews with stakeholders, 3) Site visits to CP targeted areas in three districts and two selected refugee camps, and 4) Focus group discussions with beneficiaries. Mixed methods of data collection used both primary and secondary sources and included: documentary review; financial and operations system review; structured and semi-structured face-to-face, individual and group interviews; and

observation. The analysis is based on a synthesis and triangulation of information obtained from the above-mentioned four evaluation activities. Descriptive, content, and contribution analysis was used to analyse the data. Limitations of the evaluation include its non-representative, qualitative nature due to small, non-random samples, low response rates for certain interview categories, and absence of some key stakeholders for interviews. All the interviews were done without the presence of UNFPA staff. The limitations were mitigated using comprehensive document reviews and consistent interface with the UNFPA CPE Evaluation Manager and Country Office to generate more data and insights into the programme interventions.

Main findings

Relevance: All three of the programme's thematic areas were found to be of high relevance to Rwanda's national priorities and strategies and consistent with the needs of beneficiaries and key populations. There was strong evidence that activities were developed based on sound assessments as well as consultation with stakeholders and beneficiaries. All three outcome areas were implemented in a manner reflective of Rwanda's national development framework including the first National Strategy for Transformation (NST1); UNFPA global Strategic Plans (2018–2021, 2022–2025), ICPD Programme of Action, Sustainable Development Goals (SDGs) 2030 and UNSDCF in Rwanda and business mode of operation.

Effectiveness: Despite the challenge posed by the COVID-19 pandemic, achieving success in all outputs is a significant accomplishment. UNFPA's efforts have contributed to the expansion of SRHR including HIV prevention as well as integrated services addressing sexual and gender-based violence across the nation, including in humanitarian settings. The initiatives have led to substantial improvements in the overall health-care landscape. UNFPA supported the Government of Rwanda to develop, review and update national strategies or guidelines to ensure improved quality delivery of sexual and reproductive health (SRH) and gender-based violence services, particularly for adolescents, women, girls and key populations. UNFPA supported young people to participate in decisions affecting them and strengthen their ability to advocate for human rights and development issues of health, education and employment. UNFPA also supported the inclusion of persons with disabilities in line with the 2030 Agenda principle of "leaving no one behind". UNFPA, with partners, supported in scaling up Comprehensive Sexuality Education (CSE) for in- and out-of-school youth across the country.

UNFPA developed models (e.g., First Time Young Mothers and Out-of-School CSE and Resilience Plan) to empower the most vulnerable adolescents and youth and reduce their vulnerability while increasing their resilience. A comprehensive package of services including SRH information and services, livelihood activities and small business activities, technical and vocational education and training (TVET) training, and psycho-social sessions, were implemented in the three districts and six refugee camps and reached a number of adolescents and young people, especially the most vulnerable adolescent mothers. Other achievements include strengthening the health system through supporting supply chain management, and procuring and donating essential medical equipment, life-saving medicines and contraceptives to the Ministry of Health. These efforts are strengthening the quality of SRH service delivery including family planning, comprehensive abortion care, and maternal and newborn health care.

The 8th CP contributed towards strengthening the national data management system in areas such as preparation for and implementation of the national census in 2022. The CO made technical and financial contributions towards strengthening national capacity to use administrative and population data such as civil registration and vital statistics and the Integrated Household Living Conditions Survey in line with international standards; adaptation of Washington DC disability indicators into census questionnaires and donation of Geographic Information System, tablets, and computers to the National Institute for Statistics in Rwanda (NISR). The 2022 Housing and Population census was supported technically and financially by UNFPA as the first digital census in the country.

The analysis of the theory of change (ToC) shows that the output indicators contribute to the outcomes, but the logical analysis observed some incoherence between strategic interventions, results and indicators as well as incompleteness at different levels. Most output indicators do not align with the strategic interventions. While the ToC envisages clear linkages between the strategic interventions, outputs and expected outcomes, the evaluation team noted a mismatch between the outputs and outcomes. This indicates that the outputs do not directly contribute to the outcomes as envisaged, signifying that the ToC was is not correctly formulated.

Efficiency: There is efficient use of human and financial resources in the implementation of the 8th CP interventions. In terms of human resources, the CO has qualified personnel heading some but not all units. For instance, despite population dynamics being an outcome, there is no qualified population studies expert heading the unit. There was more than 95 per cent fund utilisation. Annual programme budgets were disbursed to support the implementation of Annual Work Plans (AWPs) through agreements with Implementation Partners through National Execution and Direct Execution and UNFPA Execution modalities. UNFPA CO mobilized additional financial resources from the Government of the Republic of Korea through the Korean International Cooperation Agency (KOICA); the Government of Japan through the Japan International Cooperation Agency (JICA) and the new Strategic Investment Facility (SIF) from UNFPA; and the Swiss Agency for Development and Cooperation (SDC) through Regional Office Joint Programmes such as the Safeguarding Youth Programme. During the 8th CP, the CO followed UNFPA policies and procedures in all activities including recruitment, implementation and reporting.

Sustainability: All interventions are sustainable as the programme focused on priorities already identified by the Government of Rwanda. These initiatives align with the Government's constitutional responsibilities and emphasize district ownership ensuring long-term effectiveness and stability. The 8th CP interventions are integrated into government policies and programmes such as the Ministry of Health Strategic Plan, Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Policy, National Family Planning and Adolescent Sexual and Reproductive Health (FP/ASRH) Strategic Plan and National Youth Policy. Interventions are within existing government ministries and community structures; and capacity-building of institutions and staff. Systems strengthening is also sustainable. Development of policies and guidelines also guarantees sustainability of the 8th CP intervention results.

Coordination: UNFPA Rwanda has demonstrated proactive and constructive engagement in the coordination and operational activities of the United Nations Country Team (UNCT) in Rwanda. This demonstrates the organization's active involvement and positive influence in the collaborative initiatives, functioning and coordination of UNCT activities in Rwanda. The current UNSDCF (July 2018–June 2024) fully reflects UNFPA's mandate. The UNFPA Rwanda CO participates actively in regular UNCT inter-agency working groups and chairs two of these working groups. UNFPA is a member of the Operations Management Team, Technical Working Groups, and chairs the Monitoring and Evaluation (M&E) Technical team and Results Group 3. Existing UNCT coordination mechanisms ensure a high level of coordination and cooperation among United Nations agencies in Rwanda. UNFPA plays a proactive role in planning, implementation and coordination of United Nations joint activities such as joint proposal development for 1000 health posts; the Joint Programme on Data, and Thematic Groups on Communication, Gender and Youth. Coordination and cooperation between resident United Nations agencies enable them to combine their technical and financial resources to influence higher-level government systems. The Government's commitment to financing family planning commodities and supporting facilities for 1000 health posts are evidence of this.

Connectedness: UNFPA CO provided interventions in humanitarian situations such as in refugee camps and during the COVID-19 pandemic. UNFPA CO took a continuum approach across the humanitarian-development nexus successfully transitioning humanitarian interventions to development. UNFPA CO worked closely with the Ministry of Health to scale up midwifery education, increase capacity for delivery of emergency obstetric care and improve clinical practice for

midwifery. These skills are used in UNFPA-supported refugee health centres which are also accessible to host communities and school health clubs in the schools hosting students from communities and camps.

Cross-cutting issues: Gender equality and human rights mainstreaming is indicated but no specific programme intervention is designed to achieve this. Resource mobilization, communication, M&E and innovation systems are well aligned with the 8th CP. The M&E system is aligned with a direct output-outcome relationship, but the indicators in the CP do not capture the results of all strategic interventions. Communication is active but lacks proper funding support. While there is no permanent M&E support system, there is an M&E framework and a consultant M&E specialist. Innovative strategies were developed to accelerate activities across the three outcome areas.

Conclusions

Relevance

It is evident that the UNFPA Rwanda 8th CP 2018–2024 is aligned with both local needs and development priorities and regional and international development treaties. The 8th CP is relevant to the NST1, Fourth Health Sector Strategic Plan (HSSP IV) and other national development priorities encapsulated in relevant national policies such as Ministry of Health FP/ASRH, Ministry of Education National School Health Policy, the Ministry of Youth and Culture National Youth Policy, and the National Gender Policy of the Ministry of Gender and Family Promotion. It is also aligned with Global UNFPA strategic plans 2018–2021, 2022–2025, and other international development frameworks such as the ICPD Programme of Action and SDGs 2030. All strategies and policies developed have prioritized stakeholders needs which contributed to their relevance and effectiveness.

The 8th CP achieved most of the expected results in the outcome areas, and in 12 of 14 output indicators. The SRHR component of the 8th CP has recorded achievements in both development and humanitarian contexts. The adolescents and youth component outputs are achieved. UNFPA contributed to improved quality data on population for use in the development and humanitarian contexts and strengthen the national capacity to provide and use disaggregated data and analysis for policy planning and data utilization for evidence-based planning. The effectiveness of the 8th CP interventions is made possible by a combination of strong political leadership, availability of successful replicable models and a mix of competent staff. A critical look at the ToC shows a mismatch between the strategic interventions and output indicators. Output indicators are not linked with the strategic interventions outlined in the CP.

Most of the planned results have been achieved within the approved budget. UNFPA had a robust financial management and tracking system that facilitated programmatic and financial accountability. Regular follow up was made with implementing partners (IPs) for financial tracking, and no qualified audits have occurred. UNFPA managed to raise significant levels of financing from private sectors through the catalytic Strategic Investment Facility and from bilateral donors such as KOICA and the regional office's Safeguarding Youth Programme. UNFPA CO was creative and relatively efficient in fund raising for its interventions. Its business model of implementation through government and IPs, National Execution and Direct Execution modalities enhanced implementation efficiency and enabled UNFPA to achieve more than 90 per cent of its indicators. The Harmonised Approach to Cash Transfer (HACT) is in place and appears to work well. Inefficiencies identified include those caused by technical, operational and implementation issues (e.g. recruitment processes, lengthy procedures and waiting for approvals by government line ministries etc.).

Existing UNCT coordination mechanisms ensure a high level of coordination and cooperation among United Nations agencies in Rwanda. UNFPA is an active and proactive role player in planning and implementation of joint United Nations activities such as joint proposal development for 1000 health posts; Joint Programme on Data, United Nations Thematic Groups (Communication, Gender and Youth), interagency groups such as the UNSDCF Result Group 3 and M&E Task Team to coordinate

agency activities. The coordination and cooperation between resident United Nations agencies enable them to influence higher level government systems. The Government's commitment to financing family planning commodities and providing support for 1000 health posts is evidence of the increased influence that agencies have when combining their technical and financial resources.

Programme-level conclusions

Sexual and reproductive health: Our analysis shows that the various interventions have made a positive contribution towards reducing maternal death, gender-based violence and unmet need for family planning. To further reduce maternal deaths social actors, such as traditional and religious leaders and psycho-social medical practitioners, should be mobilized in the next programme cycle.

Adolescents and youth: The adolescents and youth interventions involving the roll out of the CSE manuals for both in- and out-of-school of youth, and the development of youth-friendly corners and youth health centres, and promotion of income-generating activities for the youth at these centres, offer sustainable and effective ways to engage adolescents and youth on SRH issues including gender-based violence. The quality of peer-educators and the vibrancy of the youth corners and economic activities show an excellent innovative model for an inclusive, participatory youth intervention.

Population dynamics: Effective contributions were made towards production of better population data via demographic and health surveys 2019/2020 and Population and Housing Census 2022, and their use for policy planning and programming. Civil Registration and Vital Statitics system is strengthened. Technical capacity for data generation and utilization was enhanced. UNFPA support enabled the development of statistical systems and capacity to the production and availability of data related to SDG indicators useful for planning, monitoring and advocacy.

Connectedness

UNFPA can respond to the need to address SRH in districts where interventions are focused, especially among refugees Most of the 8th CP interventions on SRHR and Adolescents and Youth (AY) transition to a development agenda in the community. Health posts and second-generation health centres are accessible to the host communities. However, the CO lacks an overarching strategy to address any emergency crisis as there is no dedicated staff to process humanitarian crises.

Gender equality and human rights, resource mobilization, communications, M&E, and innovative systems were developed and cut across the outcome areas of the 8th CP. Gender equality and human rights mainstreaming is indicated but no programme interventions specifically address it. Innovative strategies were developed to accelerate activities across the three outcome areas. The M&E system is aligned with a direct output-outcome relationship, but the indicator plan does not capture the results of all the strategic interventions. Communication is active but lacks proper funding support. There is no full-time M&E support system. These themes lack substantive technical units and funding support.

Recommendations

On the strategic level, it is recommended that UNFPA continue to anchor interventions on the foundations of national development frameworks, UNFPA Strategic Plan and other global development agenda. Moreover, programme interventions should be derived from research, needs assessments and prioritization by national stakeholders.

To enhance the relevance of the next CP, CO should continuously engage with local communities to ensure an understanding of evolving needs. It should strengthen partnerships with local organizations and community leaders to facilitate more targeted interventions and sustainability. It should also conduct regular reviews of programme outcomes and impact to inform adaptive strategies.

Multisectoral collaboration should be enhanced by fostering partnerships among government

agencies, civil society organizations and international partners to coordinate efforts and maximize impact. The next CP should continue to invest in institutional capacity-building for health-care providers, education, and government officials to ensure effective service delivery and policy implementation. Government and national stakeholders should develop community-level initiatives that promote awareness, education, and social norms change related to SRHR, adolescents and youth, gender-based violence and population dynamics.

It is also suggested that UNFPA should coordinate with partner United Nations agencies and IPs to include additional sustainability measures in future programming. It is recommended to leverage the Strategic Investment Facility in the context of shifting from funding to financing as a catalyst for unlocking additional resources from non-traditional donors towards the three transformative results and scale up targeted programme services to other districts. This innovative financing mechanism should be strengthened. CO should diversify resource mobilization and build more partnerships, going beyond traditional partnerships and funders. CO should establish sustainable funding mechanisms that ensure the continuity of essential services and interventions beyond short-term projects. This will enable the CO to explore more non-traditional methods to mobilize additional resources.

More policy advocacy to remove remaining legal barriers to access to SRH services and effective implementation of existing laws and policies related to the three focus areas of the next CP is needed. Evidence generation to measure change in behaviour and practice is also needed.

On a programmatic level, given that there are positive achievements in various SRHR activities, it is suggested that the same tools used to make impact in the three districts should also be extended to remote rural areas using structures developed in the 8th Country Programme. Investments should be extended to additional refugee camps. The next cycle should also focus on increasing demand for SRHR services in rural areas. Greater investment to increase the number of health posts and upgrade others to second generation health posts is needed. The next CP should give strategic support for pre-service education, ensuring the sustainability and scalability of quality reproductive health services. There should be substantial investments in expanding health-care infrastructures including establishing new Service Delivery Points (SDP) and upgrading existing facilities to advanced standards. This will ultimately advance equitable health care for all, especially in hard-to-reach areas, by investing in the expansion of services and removing financial and legal barriers to service provision.

Every effort should be made to design a specific, separate component, Outcome 3, and consider holistic interventions to address gender-based violence and adapt an integrated ecological framework for understanding the root causes of gender-based violence. Such programme should also focus on men and boys' vulnerabilities and needs in relation to gender-based violence. The next CP should focus on harmful social norms, improving help-seeking behaviours among men, women, girls and boys, and inclusive and gender-transformative interventions and human-rights programming and reporting.

The next UNFPA CP should prioritize the following focus areas to build on the achievements of 8th CP and further advance the well-being of the population: i) ensure universal access to quality SRHR services including family planning, maternal and child health and ASRH; ii) enhance efforts to promote gender equality, empower women and girls, and prevent and respond to gender-based violence through community engagement and policy advocacy; iii) scale up youth-friendly services, education, and employment opportunities to empower young people with skills and knowledge needed for a productive future, and iv) continue supporting evidence-based policies and programmes that address population dynamics, migration and urbanization, while leveraging data to inform strategic decisions.

In view of UNFPA's role in the implementation and analysis of the Rwanda Demographic and Health Survey (RDHS) 2019/2020 and Population and Housing Census 2022, there is a need for greater

UNFPA leadership, visibility and staff support for components of population dynamics. UNFPA support enabled the development of statistical systems and capacity to support the production and availability of data related to SDG indicators useful for planning, monitoring and advocacy. However, there are still gaps in the technical analytical skills for production of data, dissemination, and utilization of data for policy and programming. The next CP should invest in advanced data analytics to gain deeper insights into the needs and behaviours of target populations in the country. Data-driven decision-making can optimize resource allocation and better compare the effectiveness of interventions.

1. Introduction

1.1 Purpose and objectives of the country programme evaluation

The overall purpose of the CPE is to document an independent evaluation of the UNFPA 8th Country Programme of Assistance to the Government of Rwanda. In accordance with the UNFPA Evaluation Policy, the evaluation has the following main purposes: (i) to demonstrate accountability of UNFPA and its country office in Rwanda to stakeholders on the relevance and performance of the 2018–2024 country programme in achieving development results, (ii) to support evidence decisions for the next country programme and (iii) to identify lessons learned to expand the knowledge base on how to accelerate implementation.

The specific objectives of this evaluation are:

- To provide an independent assessment of the progress of the 8th Country Programme towards the expected outputs and outcomes set forth in the results framework.
- To provide an assessment of country office positioning within the development community and national partners, in view of its ability to respond to national priority needs while adding value to the country's development results.
- To draw key lessons from the past and current cooperation and provide a set of clear, specific and action-oriented, forward-looking strategic recommendations in light of Agenda 2030 for the next programming cycle.

The primary users of this evaluation are the decision-makers within the UNFPA and their government counterparts in Rwanda, the UNFPA Executive Board, and other development partners. The UNFPA Regional Office for East and Southern Africa and UNFPA HQ divisions, branches and offices will also use the evaluation as an objective basis for programme performance review and management response.

1.2 Scope of the evaluation

The evaluation covered activities implemented within the framework of UNFPA Rwanda 8th CP from July 2018 to June 2024 in three programmatic areas: SRHR, adolescents and youth, and population dynamics, as well as in cross-cutting areas including gender equality and human rights, resource mobilization and partnerships, M&E, and communication. Geographically, the 8th CP interventions were implemented nationally through upstream activities, and in three districts and five refugee camps through downstream interventions.

The evaluation reviewed the achievements of UNFPA 8th CP against expected results at the output and outcome levels, its compliance with the UNFPA Strategic Plans for 2018–2021 and 2022–2025, the United Nations Development Action Programme, and national development priorities and needs.

1.3 Evaluation approach

Evaluation criteria

This evaluation was informed by the UNFPA Evaluation Handbook "*How to design and conduct a CPE at UNFPA*"[35] and covered the five criteria of the Development Assistance Committee of the Organization for Economic Cooperation and Development (OECD/DAC): relevance, effectiveness, efficiency, sustainability, and coordination mechanisms of the UNCT[36]. In addition, one UN-specific evaluation criterion—connectedness—was considered. The evaluation questions were framed around the six key criteria.

[35] UNFPA (2019). Handbook: How to design and conduct a country programme evaluation at UNFPA. https://www.unfpa.org/sites/default/files/admin-resource/UNFPA_Evaluation_Handbook_FINAl_spread.pdf

[36] UNFPA CPEs cover all OECD-DAC evaluation criteria with the exception of the impact. This evaluation will also not assess impact due to the lack of required data for in-depth analysis.

These criteria are defined as: **relevance** (the extent to which the 8th CP corresponded to population needs at country levels, in particular those of vulnerable groups, and was aligned throughout the programme period with government priorities and UNFPA strategies); **effectiveness** (the extent to which the 8th CP outputs have been achieved and the extent to which these outputs have contributed to the achievement of the country programme outcomes); **efficiency** (the extent to which the 8th CP outputs and outcomes have been achieved with the appropriate number of resources, i.e. funds, expertise, time and administrative costs etc.); **sustainability** (the extent to which the benefits of the 8th CP interventions will continue after its termination, linked in particular to their continued resilience to risks); **coordination** (the extent to which UNFPA has been an active member of and contributor to existing coordination mechanism of the UNCT, including membership of and contributions to humanitarian coordination mechanisms of the humanitarian country team (HCT), where applicable; extent to which the UNFPA CO harmonized interventions with other actors, promoted synergy and avoided duplication); and **connectedness** (the extent to which activities of a short-term emergency nature are carried out in a context that takes longer-term and interconnected problems into account).

In addition, the CPE assessed cross-cutting elements of the 8th CP, notably the **M&E system** (the extent to which the institutional M&E system of the programme has enabled the effective collection, circulation, and reporting of data, favouring the monitoring of the achievement of programme results, decision-making and accountability) and the **communication system** (the extent to which the institutional communication mechanism has enabled the dissemination of the program's actions to beneficiaries and other stakeholders and ensured the visibility of its interventions both internally and externally). Furthermore, the extent of such cross-cutting elements of innovation, resource mobilization and strategic partnerships were factored into the interventions.

Table 1: Evaluation criteria and evaluation questions

Criteria	Questions
1. Relevance	To what extent does the UNFPA Rwanda 8th Country Programme align with (i) Rwanda's development priorities; (ii) UNFPA's global strategic plans; and (iii) the needs of the intended beneficiaries, namely women, young people, and vulnerable populations including people with disabilities and key populations? (iv) To what extent has the programme remained relevant and responsive to changing circumstances and varied needs of the population? Were there any unintended consequences or negative impacts on the intended and/or unintended beneficiaries or other stakeholders, and how were they addressed?
2. Effectiveness	To what extent has the 8th CP contributed to (i) increasing access and use of integrated SRH services; (ii) increasing knowledge and skills in young people, particularly girls to make informed decisions about SRHR and fully participate in development and humanitarian actions; and (iii) enhancing generation and use of disaggregated data to inform policies and programmes? (iv) To what extent has UNFPA successfully integrated human rights, gender perspectives and disability inclusion into the country programme?
3. Efficiency	To what extent has UNFPA made good use of its human, time, financial and technical resources to pursue the achievement of the outcomes defined in the county programme? Were the programme activities and outputs produced in a cost- and time- efficient and quality manner?
4. Sustainability	To what extent has UNFPA been able to support implementing partners and rights-holders (notably, women, adolescents and youth) in developing capacities and establishing mechanisms to ensure the durability of effects?

5. Coordination	To what extent has UNFPA contributed to the functioning and consolidation of the coordination mechanisms with other development stakeholders including the government, civil society, development partners, and UNCT for the development of Rwanda? To what extent has the UNFPA Rwanda Country Programme created synergies with other development programs and policies in Rwanda, to amplify results of the national agenda?
6. Connectedness	To what extent has UNFPA contributed to developing the capacity of local and national actors (government line ministries, youth and women's organizations, health facilities, communities, etc.) to better prepare for and respond to refugee situations?

Evaluation questions and assumptions

Standard questions were formulated to translate the abstract analytical perspectives of evaluation criteria into concrete language and conceptual components of the UNFPA Country Programme. These questions captured the main elements of the Government of Rwanda/UNFPA 8th Country Programme. (See the Interview Guides: Annex 4).

Evaluation matrix

The evaluation matrix is a reference framework developed to check that all evaluation questions were being answered. It specified what was evaluated and how it was evaluated. It also specified the evaluation questions for each thematic area, assumptions assessed under each question, and the indicators, sources of information, methods and tools used for the data collection. (See Annex 1)

This section presents the evaluation framework including evaluation criteria and questions, overall approach to answer evaluation, evaluation sample, data collection methods, approach to data analysis, limitations encountered and mitigation measures used, and evaluation process. The evaluation followed the principles of the United Nations Evaluation Group norms and standards, in particular with regard to independence, objectiveness, impartiality and inclusiveness, and is guided by the United Nations Evaluation Group Ethical Guidelines for Evaluation[37]. The field work took place during the period of July to August 2023 and covers the Rwanda 8th CP activities from 1 July 2018, to 30 June 2023.

1.3.1 Process overview

There were five phases of the evaluation process.

Preliminary phase: During the **preparatory phase** in late February 2019, the UNFPA country office in Rwanda put together an Evaluation Reference Group (ERG) consisting of representatives of national partners, including the Ministry of Health, Ministry of Youth, Rwanda Education Board, Rwanda Biomedical Centre, and the UNCT. Members of the ERG provided input to the evaluation ToR. Deliverables: established ERG, Terms of Reference (ToR) finalized with inputs from the ERG.

Inception phase: This involved the development of an inception report which included document reviews with UNFPA stakeholders, development of the reconstructed ToC, evaluation design matrix, evaluation questions, data collection methods, data sources, and an analysis plan. These components were collated in the assignment Inception Report, which builds on the ToR to become the primary guidance for the evaluation team. This Inception Report went through several iterations based on feedback from ERG members, the Evaluation Manager and Head of Programmes

[37] United Nations Evaluation Group (2020). Ethical Guidelines for Evaluation. www.unevaluation.org/ethicalguidelines

The Evaluation Manager provided important programme and national documents, such as the Country Programme Document, through repository folders. The evaluation team gained a better understanding of the 8th CP context and procedures in Rwanda through continuous consultation with UNFPA CO staff. evaluation questions were framed using the selected six evaluation criteria, as shown in the evaluation matrix below (Annex 1).

Field phase: This consisted of a two-week period of virtual interviews with some key stakeholders based in Kigali and a two-week field mission in Rwanda to collect data. The team collected data through document reviews, interviews, group discussions and field visits to intervention locations.

The evaluation team used the final week of the field phase to conduct follow-up interviews with selected key informants in the CO and relevant government departments to fill data gaps. The first workshop on return from the field was to debrief UNFPA CO and allow an opportunity to provide input into the subsequent analysis and reporting phases. This debriefing was important for several reasons: (i) it provided the opportunity to review the data and information collected and to present the preliminary findings; and (ii) feedback helped to identify possible weaknesses or gaps in the collected evidence requiring review or adjustment of findings. This opportunity was used to introduce and discuss possible conclusions and corresponding recommendations. The exchange with CO staff helped to identify gaps in the chain of reasoning behind the conclusions which ultimately helped to enhance their validity and credibility, thereby contributing to more realistic, feasible, and operational recommendations.

The analysis and reporting phase - findings, conclusions, and recommendations: The reporting phase opened with an analysis workshop to help the evaluation team to deepen their analysis with a view to identifying the evaluation's findings, main conclusions, and related recommendations in the final report.

Throughout the field phase, each member of the evaluation team completed an individual copy of the evaluation matrix with the data and information collected during the document reviews, interviews and focus group discussions (FGDs). The team leader reviewed and consolidated all information into the evaluation matrix (Annex 1). All data in the consolidated evaluation matrix was reviewed to decide what information was necessary and of sufficient quality to inform each evaluation question indicator. Findings logically flow from the information related to indicators. Conclusions on the performance of the Country Programme were drawn from the answers to the evaluation questions.

Final evaluation report phase: This was the last stage of the evaluation. At the core of this report is (i) a presentation of the findings, (ii) conclusions from the findings, and (iii) recommendations. Supporting evidence has been presented within the evaluation matrix. This report also explains the evaluation purpose, objective, scope, and methodology and provides an overview of the country context and the UNFPA Country Programme. The draft of the synthesis report, including tentative conclusions and recommendations, was presented by the evaluation team during a stakeholder workshop (attended by the ERG as well as other relevant stakeholders). Based on feedback from this workshop, the evaluation team finalized conclusions and recommendations and submitted the final report for approval by the Evaluation Manager in consultation with the ERG.

1.3.2 Contribution analysis and theory of change

A central reference point for this evaluation is the reconstructed ToC that governs UNFPA's 8th CP in Rwanda. The evaluation of the continuum of interventions entailed a reconstruction of the

intervention logic of the UNFPA response to the Rwandan population needs, i.e., the ToC meant to lead from planned activities to the intended results of UNFPA interventions. The analysis of the soundness of the 8th CP result chain is contributive links of the CP outputs to the 8th CP outcomes. This is based on the assumptions contained in the 8th CP document. The evaluation team applied the concepts of "plausibility, reasonable agreement, embeddedness and testability to systematically investigate the intervening steps in the 8th CP logic presumed to be responsible for achieving results".[38]

The reconstructed ToC for the Evaluation of the 8th CP is grounded in UNFPA's overall mandate and purpose, which has not substantively changed in its articulation across different Strategic Plans relating to the evaluation period. Simultaneously, this ToC aligns with the Rwanda development objectives as articulated within national strategic development frameworks. The ToC was reconstructed based on actual results since it was not a requirement at the time of submission of the CP documents but rather mainstreamed in the actual write up of the Country Programme Document. The current ToC was built based on the rationales, strategies and Results Framework of the CP; and was reconstructed to include both UNFPA Strategic Plans 2018–2021 and 2022–2025, changes in business model and modes of engagement, as well as the UNSDCF of the United Nations Rwanda that was revised from the United Nations Development Assistance Plan in 2021. The ToC shows that the 8th CP of UNFPA Rwanda focused on the areas of sexual reproductive health, adolescents and youth, and population dynamics, by engaging in policy advocacy, capacity building and service delivery to contribute to the achievement of UNFPA's Transformative Results in Rwanda; Rwanda UNSDCF Outcomes 3, 4 and 6; and the Social Transformation Outcome Pillar in the NSTI in Rwanda.

The ingredients used in the construction of this theory are the types of intervention strategies or modes of engagement in the CP, the principles guiding UNFPA interventions, the elements of the intervention logic, the type and level of expected changes, and the external factors that influence and determine the causal links depicted in the ToC diagram. The intervention strategies of the 8th CP include capacity development, technical assistance and training; service delivery; health systems strengthening; and advocacy and policy. These strategies are guided by the principles of human rights, gender equality and leaving no one behind.

The elements of the intervention logic are inputs (human and financial resources, administrative arrangements, systems, agreements, and contracts with IPs and consultants); intervention activities (different modes of engagement); outputs (the immediate or short-term improvements generated once the activities have been completed); and outcomes (short- and medium-term changes in conditions or effect) corresponding to tangible improvements compared to the baseline situation of target beneficiaries. They imply an improvement in the quality of life of beneficiaries and lasting impact (long-term changes on the population in terms of improvements in their conditions). This theory simply assumes that when the inputs are implemented as intervention activities there would be a change in the quality of life of the beneficiaries of the CP.

In 2022, UNFPA Rwanda CP interventions logic and results framework was aligned to the new UNFPA SP 2022–2025. Under this new alignment, CP outputs 1 and 2 contribute to SP outcome 1, SRHR. CP output 3 contributes to the achievement of SP outcome 2, adolescents and youth

[38] Janice S. Biggs et al (2014): A practical example of contribution analysis to a public health intervention. Evaluation, Vol 20(2):214–229

development. CP output 4 contributes to SP outcome 4. SP outcome 3, gender equality and empowerment, is not included as it is treated as a cross-cutting theme. However, UNFPA indicators are not well aligned with a direct output-outcome effect relationship and appropriate indicators.

Analysis of the ToC shows that the CP outputs when achieved will likely contribute to the strategic level outcomes. It is expected that SP outcome 1 and the direct effect relationship with outputs 1 and 2. UNFPA CP indicators consist of 15 output indicators and 5 SP outcome indicators. Going by the 8th CP, the 15 output indicators have nothing to contribute to the outcomes, simply because the indicators were not well defined. For example, outcome 1 and outputs 1 and 2 are not linked but when examined according to the actual intervention activities carried out (advocacy, policy dialogue, strategies and capacity building, and downstream activities will contribute to the outcome indicators. These interventions and ensuing results are not captured in output terminology nor are they reflected in the indicators.

Reviewing the strategic activities, the evaluation team noted the statements are generic and lack explicit guidance and directions on how to achieve them. There is no clear strategy on what activities are to be implemented.

The analysis of the results chain and the ToC regard their soundness and how they worked in practice. Regarding soundness, light is shed on the contribution of the output to the outcome, the coherence between the result framework elements, as well as the coverage and robustness of the indicators. The analysis found that logically, the contribution of the output to the outcome is not generally obvious. The intervention logic was designed as a single output-outcome relationship showing that one CP output contributes to the achievement of the SP outcome. According to the ToC, the three outputs were to contribute jointly to the achievement of SP outcomes.

The 8th CP Resource and Results Framework defined a set of performance indicators with corresponding baselines, end of programme targets and means of verification. The CO has been reporting on programme progress and achievements through the Country Office Annual Reports. Monitoring of programme performance data and indicators is reported yearly in performance monitoring plans that track progress and achievement of output indicators against planned yearly targets.

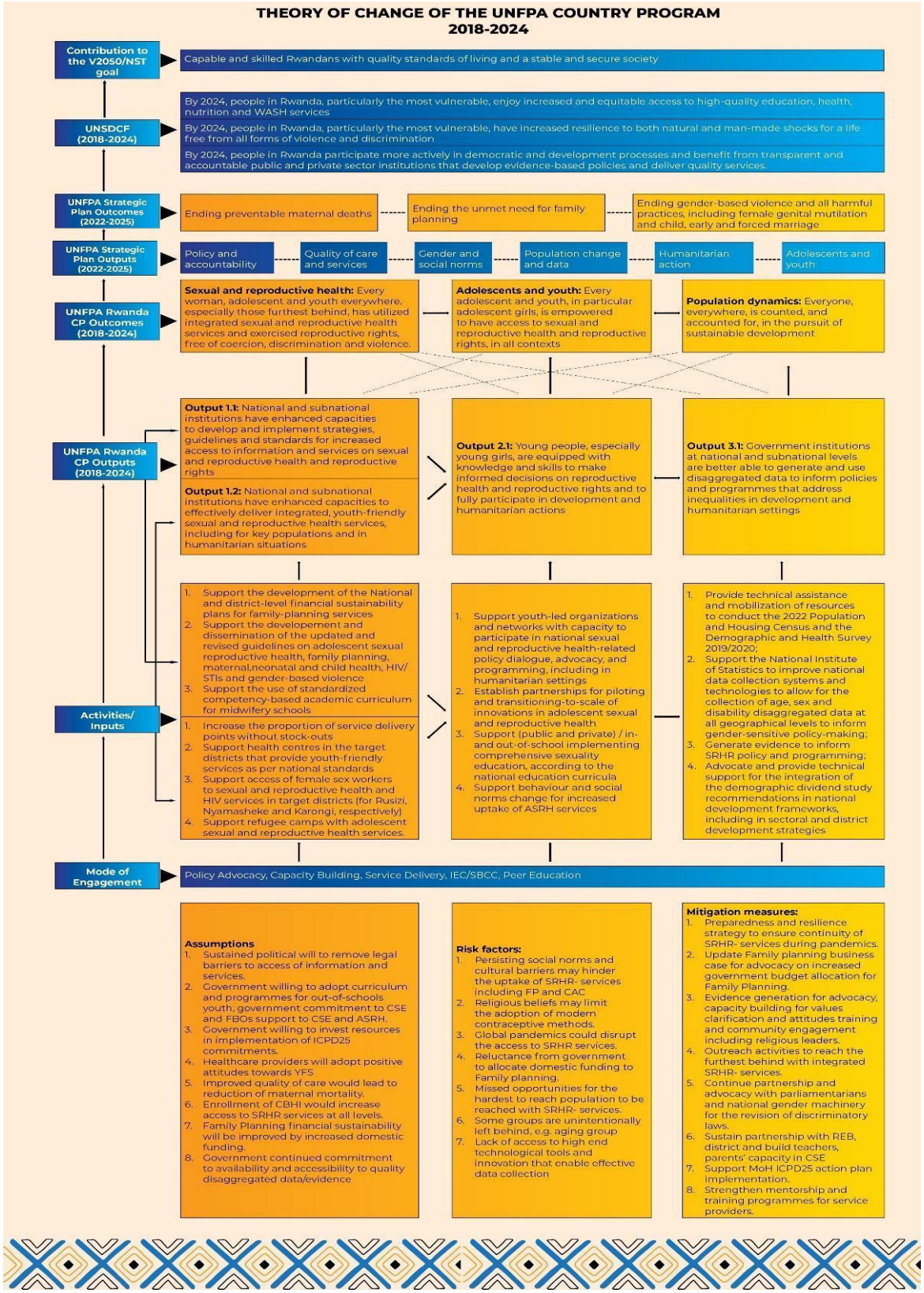


Figure 1: Reconstructed Theory of Change, 8th Country Programme of Rwanda

A critical review and analysis of the ToC reveals that the system intervention logic is not well aligned with a direct output-outcome effect relationship and appropriate indicator measures. While the ToC stipulated that CP outputs will likely contribute to strategic level outcome, there is a clear mismatch between the outputs and their indicators. Output 1 and its strategic interventions can contribute to the outcome 1 cumulatively. Output 2, its indicators, and strategic interventions are mismatched. The listed interventions cannot lead to the output indicators, even though the indicators can contribute to the outcome. Thus, there is a problem of a problem of coherence between output 2 and its indicators. While the outcome relates to the empowerment of adolescents and youth to access SRHR, the indicator relates to participation in the formulation of policies. However, participation in policy formulation does not directly relate to access to SRHR, which raises the need to have a more coherent outcome indicator.

As mentioned above, the output contributed to the outcome, though indicators defined to measure the contribution are not robust. But the contribution lies in creating knowledge, skills, behaviours, habit, and power among youth to use adolescent SRHR services. All categories of youth beneficiaries of the programme have stories to tell about change whether they are using family planning, have prevented unintended pregnancies, or are influencing SRH policies.

Connections between activities, strategies, outputs, and outcomes are not clear and logical. Indicators do not fully capture all intended results. Due to the shortcomings described above, the CP Results and Resources Framework, annual work plans and SPRs don't allow for proper tracking of CP progress or making judgements about programme effectiveness. The changes supported by the CP are better described as transformation of several national systems supported by UNFPA such as the perinatal care system, male reproductive health care system, and system for delivery of reproductive health education in schools. The process of transformation includes several consecutive stages.

1.3.3 Methods for data collection and analysis

The methods of data collection and analysis were determined by the type of evaluation questions, assumptions, and indicators chosen to test the assumptions as indicated in the evaluation matrix (Annex 1). Data sources were a mix of primary and secondary sources. Primary sources include key informant interviews (KII), in-depth interviews (IDI), FGDs, and site visits for observations of intervention facilities and activities. The secondary source was a desk review of UNFPA CO Programme and Rwandan National Government documents. Data collection was done with a sensitivity to issues of discrimination and other ethical considerations. The purpose of interviews was explained to participants who were informed that they were able to terminate the interview at any point if they felt uncomfortable. All participants freely granted the permission to proceed with the interviews. Confidentiality was maintained throughout the data collection and analysis process.

Document review

The evaluation team started with review of the key documents related to the country programme: UNFPA Rwanda 8th Country Programme Document (CPD), Annual Work Plans for 2018–2023, UNFPA CO Annual Reports for 2018–2023, and Atlas data on budget allocations and actual expenditures. The evaluation team also reviewed a broad range of documents provided by the CO and national stakeholders before, during and after the field phase. These documents included evaluation and activity reports; strategic, methodology, and analytical documents produced within the framework of the CP; and relevant national strategic and policy documents. The evaluation team also reviewed available national and international statistics from RDHS and development agencies sourced from their individual dashboards. Document review was an important data source to understand the country

context of the 8th CP; to identify the sample of stakeholders, collect both quantitative and qualitative data, identify specific interview questions, complete the evaluation matrix, and validate and crosscheck preliminary findings. Information and data collected from the document review would include the description and analysis of needs among beneficiaries at sub-national (district) levels; inputs/resources, activities, planned and actual outputs, actual achievements at the level of the 8th CP outcomes, etc. Several documents were reviewed (Annex 7).

Key informant interviews

Key staff from the UNFPA CO (management, programme and operations staff), key government ministries and agencies (Ministry of Health, Ministry of Youth; National Institute for Statistics), Rwanda Biomedical Centre, University of Rwanda/College of Medicine and Health Sciences/School of Midwifery, Rwanda Education Board, district officials, relevant development partners (multilateral and bilateral institutions), and civil society organizations, were identified and engaged in KII sessions. In all these sessions, the key staff were accompanied by colleagues to assist in providing answers as needed.

In-depth interviews

With the assistance of IPs, programme beneficiaries for each of the programmatic areas were identified and randomly selected for in-depth interviews. Both programme managers of IPs and their beneficiaries were recruited for this. In-depth interviews helped to collect information on how assets, financial and human resources, or other direct deliverables associated with UNFPA support were utilized and the extent to which this improved key programme outcomes in the country. Questions on challenges and factors affecting the interventions were asked.

Focus group discussions with beneficiaries

Nine FGDs were used to collect information among programme beneficiaries in the five districts and four refugee camps. Focus group guides were prepared and used to conduct the FGD sessions. The aim was to solicit opinions on the relevance and quality of the training with particular focus on the services received. The evaluation team visited both health and youth centres supported by UNFPA in the three districts. In each of the districts and intervention sites, FGDs with beneficiaries of health centres, health posts and youth corners were organized. The evaluation team embarked on a tour of sexual and reproductive and youth-friendly facilities which provided the team with a view of the achieved results. The evaluation team then conducted a group discussion with peer educators and first-time young mothers on their level of knowledge about reproductive health issues and their experience of using of reproductive health services. In each district, the evaluation team conducted the FGD with out-of-school youth, first-time young mothers and beneficiaries of health centres and youth corners. Heads of the health centres and youth corners were also interviewed.

Data validation

In each of the primary qualitative data collection activities, perceptions were drawn out through interviews with internal and external stakeholders and key informants. Validation was achieved through stakeholder meetings such as debriefings with UNFPA CO staff and the members of the ERG (composed of CO staff, the Regional Office M&E Advisor, government partners and IPs). The evaluation also used reports submitted by IPs and UNFPA CO staff including M&E and annual reports. Moreover, data validation was sought through regular exchanges with the CO programme outcome leads, district programme coordinators and evaluation manager. The evaluation matrix ensured that a multitude of data sources were considered, and the evaluation team was able to triangulate the data to adequately provide answers to each question (Annex 1).

Methods of data analysis

Data analysis involved several stages. During the data collection process, members of the evaluation team held regular debriefing meetings to compare and validate data from interviews and discuss preliminary analyses of the topics and themes emerging from the data. At the end of the field phase, the team leader conducted two analysis workshops for the evaluation team. During these sessions the evaluation team separately reviewed evidence collected for each of the government systems targeted by the CP to identify the relevance of the implemented intervention, achievement of intended outputs and outcomes and their sustainability, as well as the use of resources, and factors of success and failure. In the process of this analysis, the team triangulated data from different sources and by different methods to identify consistent topics, themes, and patterns. The results of the analysis were presented to members of the ERG for validation.

The evaluation team used three analytical approaches. The first was descriptive analysis which was used to understand the context of the 8th CP. This involved document review and interviews. The second was content analysis used to analyse and code documents and interview transcripts for each of the evaluation questions and criteria. The third was contribution analysis to examine how the output indicators contributed to the outcome levels. Findings from the analysis of the individual systems were further analysed to construct answers to individual evaluation questions as well as to identify common and specific factors of success and failure. Data analysis was gender-disaggregated allowing for a clearer understanding of how programs specifically targeted and affected women and girls.

To increase the quality and credibility of the findings and conclusions, the evaluation team used the data collected to triangulate and validate the findings. Preliminary findings were presented to the CO on 23 August 2023, after the conclusion of the fieldwork. There were several debriefing sessions during and after the fieldwork. A final stakeholders' workshop was organized to synthesize and validate the results of the evaluation, while the ERG and RO provided their feedback which was incorporated into the final revision.

1.3.4 Stakeholders consulted, sampled and sites visited

As in all UNFPA CPs, a range of stakeholders were involved including: the 8th CP programme management and staff, implementing partners (government and non-governmental) agencies, direct and indirect beneficiary groups, donors, ministries and agencies (Ministry of Health, Ministry of Youth, National Institute for Statistics, Rwanda Education Board), academic (School of Public Health, University of Rwanda, Swiss Tropical and Public Health) and civil societies (Society for Family Health etc.). The identification of the sample of stakeholders revolved around the intervention areas.

A sample of stakeholders was selected from the stakeholder mapping (Annex 3). The stakeholder sample included (i) implementing partners, agencies, beneficiaries, and donors; (ii) for each output or outcome, stakeholders associated with ongoing activities as well as with activities that have already been completed; (iii) stakeholders related to parts of the programme implemented in the country capital and districts; (iv) stakeholders associated with district interventions, and any other useful stakeholder. The samples selected have been determined on the basis clearly stated in Table 10.

The CO programme leadership, outcome leads and technical officers at the national level are relevant to the evaluation questions. National stakeholders such as the Ministry of Health, Ministry of Youth, National Institute for Statistics, Rwanda Biomedical Centre, Rwanda Education Board were selected. For IPs, both government institutions and non-governmental organizations were selected.

Beneficiaries included women attending antenatal clinics, adolescents at adolescent and youth centres, first-time young mothers, women at family planning clinics, and student midwives at the School of Midwifery. For development partners, UNCT and donors such as KOICA, SDC and Belgium Development Agency were selected.

Selection of sites for field visits was also purposeful. The evaluation team visited three out of the five intervention districts to see what impact the country programme had on their operation. Youth corners and health centres supported by the 8th country programme were in the districts of Karongi, Rusizi and Nyamasheke. The team also visited other institutions at the selected sites that were involved in and could have been impacted by the country programme. Table 2 below presents the composition of the evaluation sample in terms of stakeholders reached in specific locations. Table 3 presents the coverage of the evaluation sample for the 8th CPE.

Table 2: Types of stakeholders reached by the evaluation team

Location	Types of stakeholders reached by the evaluation team
Kigali	UNFPA CO Other United Nations agencies National partners/implementing partners
Nyamasheke	Health centres/posts providing maternity and RH services Youth corners, youth centres and youth-friendly spaces
Karongi	District level 2nd level health centres providing maternity and SRH/FP services Refugee camp
Rusizi	District level 2nd level health institutions providing maternity and SRH/FP services

Table 3: Coverage of the evaluation sample for the 8th CPE in Rwanda

Institutions	Key informant interviews/in-depth interviews	Focus group discussion		Total
		Male	Female	
UNFPA	9	3	6	9
Government stakeholders	7	5	2	7
UNCT	3			3
SRHR				
UNFPA	5			
National	2		33	35
District government	2			
Implementation partners	15			
Adolescents and youth				
National	1			1
District	2			2
Implementation partners	8		9	17
Population dynamics				
National	2	2		2
Implementation partners	2			2
Cross-cutting issues	4			4
Total				113

Site visits and observation

The evaluation team used the third week of the field phase to visit some intervention districts and sites. Before departure, the evaluation team, prepared a brief scope of work for the field visits: (i) Set out the purpose/objectives of the visit; (ii) Explain the methodology to be applied (including presentation of the research tools); (iii) Introduce a draft agenda for the visit; (iv) List and discuss the key individuals to be interviewed; and (v) Specify any logistical requirements of the evaluation team.

The evaluation manager appointed evaluation focal points for each district who were given the opportunity to provide feedback and input on the fieldwork prior to finalization of the scope of work, as well as to provide further details on key personnel and documentation to be included in the evaluation visits. The focal persons assisted in arranging meetings and logistics for the field visit.

The evaluation team visited several health facilities and youth facilities that benefited from UNFPA programme support. These site visits were used to assess usage and effectiveness of SRH services provided to community beneficiaries through UNFPA assistance. Facility managers were also interviewed during this period. The evaluation team selected refugee camps and districts where various intervention activities are taking place. Refugee camps, adolescent and youth facilities and health care facilities were assessed at each site visited and site managers and beneficiaries were interviewed.

Table 4: Distribution of evaluation questions by evaluation criteria and level of analysis

Level of analysis	Programme	Evaluation criteria	SRHR	Adolescents and youth	Population dynamics
Programmatic analysis	Design	Relevance	EQ 1	EQ 2	EQ3
	Process	Efficiency	EQ 3	EQ 3	EQ3
	Results	Effectiveness	EQ2	EQ2	EQ2
		Sustainability	EQ4	EQ4	EQ4
Strategic positioning	Coordination	EQ5			
Humanitarian programming	Connectedness	EQ6		EQ6	

1.3.5 Limitations and mitigation measures

A few limitations were encountered. Firstly, major aspects of the interventions were not explored due stakeholders being available for interviews. School youth clubs, teachers of CSE and heads of religious groups were not found to be interviewed. Secondly, due to staffing changes, some IP representatives could not respond clearly to the questions, principally because they were new to their offices. The only feasible mitigation measure, given the timeframe available for the evaluation, was to conduct a deeper and wider review of available programme implementation documents and reports.

2. Country context

2.1 Development challenges and national strategies

Rwanda is a small and landlocked country in East Africa bordered by Uganda to the north, Tanzania to the east, Burundi to the south, and the Democratic Republic of the Congo to the west. It has a surface area of 26,338 km^2, is largely mountainous, and is often referred to as "the land of a thousand hills". The country is structured into 30 administrative districts in four provinces comprising East, West, North, South, and the City of Kigali. Most of the population lives in rural areas (72.1 per cent), with agriculture being the primary source of income.

The total population was 13.2 million in 2022. Rwanda has a youthful population, with 65.3 per cent under 30 years of age and 56 per cent between the ages of 16 and 64 in 2022. The total fertility rate is 3.6 births per woman and the annual growth rate is 2.3 per cent. The country is one of the most densely population in Africa having increased from 321 to 416 persons per square kilometre between 2002 and 2012[39]. The country is densely populated, with a current population density of around 503 people per square kilometre.

Rwanda's economic growth is driven by the country's services sectors and public investments, some of which are being funded by foreign aid. There has been some degree of export diversification in the country away from coffee (the country's predominant historical export). The rapid growth of tourism has also been vital for managing the country's large trade deficit.

Rwanda's economy has been growing at a steady pace, with an average growth rate of 8 per cent over the past decade. Rwanda aspires to Middle Income Country status by 2035 and High-Income Country status by 2050. It plans to achieve this through a series of seven-year National Strategies for Transformation (NST)[40], underpinned by sectoral strategies focused on meeting the United Nations SDGs. The NST1 followed two, five-year Economic Development and Poverty Reduction Strategies (2008–12 and 2013–18), during which Rwanda experienced robust economic and social performance. Growth averaged 7.2 per cent per year over the decade to 2019, while per capita gross domestic product (GDP) grew at 5 per cent.

Strong economic growth was accompanied by substantial improvements in living standards. Rwanda was one of two countries in Sub-Saharan Africa that achieved all health-related Millennium Development Goals. A strong focus on homegrown policies and initiatives has contributed to significant improvement in access to services and human development indicators. Rwanda has implemented a successful business reform agenda over the last 10 years to create a favourable and competitive business environment. As a result, Rwanda now ranks as the second easiest country in Africa to do business (39th globally)[41].

The economy showed resilience despite a challenging economic environment in 2022. After a strong

[39] United Nations (2018). United Nations Sustainable Development Cooperation Framework (UNSDCF) 2018–2024. Kigali

[40] National Strategies for Transformation 2018–2024. The NST1 provides a platform and pillars for accelerated transformation of the economy and society towards the prosperity sought by Vision 2050. The NST1 is founded on the adoption of home-grown solutions based on Rwandan culture, values, and the country's unique development context. The Strategy also prioritizes the role of the private sector as the driver of economic growth while emphasizing sustainability of results and inclusiveness of development for all by advancing equality and without leaving anyone behind. The NST1 integrates global and regional commitments that guide its design and implementation.

[41] World Bank (2020). Doing Business Report. https://openknowledge.worldbank.org/bitstream/handle/10986/32436/9781464814402.pdf

rebound in 2021 from the COVID-19 economic contraction in the preceding year, the economy faced multiple challenges in 2022—pandemic scars, headwinds from the war in Ukraine, climate-related shocks and mounting inflationary pressures. Despite these challenges, real GDP grew by 8.2 per cent in 2022.

The Human Development Index (HDI) is a measure of the quality of life in a country, which considers factors such as education, health care and income. Rwanda's HDI score was 0.534 as of 2021[42], which is considered low. However, the country has made significant progress in improving its HDI over the past decade, with an average annual increase of 1.88 per cent. Rwanda has implemented policies aimed at reducing inequality, such as increasing access to education and health care for all citizens.

Rwanda's Vision 2050 articulates the long-term strategic direction for "the Rwanda we want" and the enabling pathways to achieve this ambition. Energized by the past two decades of success in reducing poverty, increasing incomes, improving living standards, strengthening good governance, promoting homegrown solutions, establishing the rule of law, maintaining stability, promoting gender equality and women empowerment, peace and security, Rwanda now aspires to transform its economy and modernize the lives of all Rwandans[43].

Recognizing that achieving these aspirations will require bold and decisive action, Vision 2050 serves as the critical planning and policy blueprint to guide the efforts of all players in Rwanda's development, including Government, private sector, citizens, diaspora, civil society, faith-based organizations, development partners, academia and research institutions, and political parties. Vision 2050 establishes the development framework for 2020–2050, with a mid-term review envisaged in 2035 and regular reviews planned every five years. Vision 2050 intensifies the country's ambitions and continues the drive towards self-reliance and competitiveness[44]. Rwanda now aspires to middle-income status by 2025 and high-income status by 2050.

2.2 Sexual and reproductive health and rights

Analysis of the status of SRHR in Rwanda shows that maternal mortality ratio is 203 maternal deaths per 100,000 livebirths and 98.5 per cent of births occurred in health facilities. Also, 5.2 per cent of women aged 15–19 have begun childbearing; 4 per cent have given birth and 1 per cent are pregnant with their first child [45]. At the district level, this varies from 0.5 per cent in Karongi district to 6.6 per cent in Nyabihu district, 4.7 per cent in Rusizi and 2.2 per cent Nywamasheke. The percentage of women aged 15 to 49 receiving antenatal care at district level is 99 per cent in Rusizi and Nyamasheke and 97 per cent in Karongi. Ninety-eight per cent of mothers in Rusizi and Nyamasheke districts deliver in a health facility and 935 of the same population deliver at a health facility at national level. Ninety-eight per cent of women aged 15–49 who gave birth in the five years preceding the RDHS 2019–2020 received antenatal care from a skilled provider during pregnancy for their most recent birth, forty-seven had at least four antenatal care visits.[46]

[42] National Institute of Statistics of Rwanda (NISR) (2023). The Fifth Rwanda Population and Housing Census, Main Indicators Report. Kigali: NISR021
[43] National Strategies for Transformation (NST 1): Economic Development and Poverty Reduction Strategies 1 and 2 (EDPRS 1 & 2).
[44] World Bank. The World Bank in Rwanda. https://www.worldbank.org/en/country/rwanda
[45] National Institute of Statistics of Rwanda (NISR), Ministry of Health (MOH), and ICF (2020). Rwanda Demographic and Health Survey 2019–20. Key Indicators Report. Kigali, Rwanda, and Rockville, Maryland, USA: NISR and ICF.
[46] Ibid.

At National level, RDHS 2019/2020 shows that 58 per cent of married women aged 15 to 49 use a modern family planning method, while 6 per cent use a traditional method. The proportion of women currently using contraceptive methods in the three key districts is highest in Karongi district (68 per cent) and similar in Rusizi (57 per cent) and Nyamasheke (59 per cent). Seventy per cent of men reported using a condom during the last sexual intercourse with a partner. The tendency to initiate sexual intercourse before age 15 is higher among men than women (10.1 per cent versus 4.5 per cent)[47]. The percentage of women with comprehensive knowledge about HIV varies by age, from 54 per cent among those aged 15–19 to 69 per cent among those aged 40–49. The percentage of men with comprehensive knowledge of HIV increases from 55 per cent among those aged 15–19 to 70 per cent among those aged 30–39 before dropping to 66 per cent among those aged 40–49[48] (DHS 2019–20).

The contraceptive prevalence rate is 64 per cent among currently married women aged 15–49. Most currently married women using contraception use a modern method (58 per cent), while 6 per cent use a traditional method. Fifty per cent of sexually active, unmarried women use a contraceptive method, (48 per cent using a modern method and 2 per cent using a traditional method). However, 14 per cent of currently married women aged 15–49 have an unmet need for family planning (7 per cent each for limiting and for spacing); this has consistently decreased over time, from 39 per cent in 2005 to 14 per cent in 2019–20. Implants and injectables are the most used modern family planning methods among both currently married women (27 per cent and 15 per cent, respectively) and sexually active unmarried women (22 per cent and 15 per cent, respectively). Only a small proportion of currently married women who do not have a child use a modern contraceptive method (3 per cent). Among women with children, modern contraceptive use is higher among those with three or four children (66 per cent) than among those with one or two children (62 per cent) and those with five or more children (52 per cent)[49].

Rwanda is committed to achieving the SDGs by 2030 and has declared family planning (FP) and adolescent sexual reproductive health (ASRH) a national priority for poverty reduction and socioeconomic development of the country. The Government's FP/ASRH Strategic Plan has a well-defined set of objectives and responsibilities.

2.3 Adolescent and youth sexual and reproductive health

Adolescents and youth (aged 10–29 years) represent 39.6 per cent of the Rwandan population (40.3 per cent among males and 38.9 per cent among females). The proportion is slightly higher in urban areas than in rural areas (41.0 per cent vs 39.0 per cent). Youth (aged 16–30 years) represent 27.1 per cent (27.5 per cent and 26.8 per cent among males and females), 31.4 per cent and 25.5 per cent in urban and rural areas respectively. One in three (29.7 per cent) of the youth population are married, predominantly women (35.9 per cent versus 23.4 per cent for men) and people living in rural areas (30.9 per cent versus 27.2 in urban areas)[50].

Women who have ever experienced sexual violence account for 13.3 per cent of those aged 15–19 years, 23.6 per cent in the 20–24 age bracket, and 25.5 per cent of those aged 25–29 years. Perpetrators are mostly current husbands/partners (42.9 per cent) and/or former husbands/partners

[47] Ibid.
[48] Ibid.
[49] Ibid.
[50] National Institute of Statistics of Rwanda (NISR) (2023). The Fifth Rwanda Population and Housing Census, Main Indicators Report. Kigali: NISR

(27.0 per cent) for those who were ever married; and friends (51.7 per cent), strangers (17.6 per cent) and family friends (8.5 per cent) for those who were never married. Men who have ever experienced sexual violence account for 3.2 per cent of those aged 15–19 years, 6.6 per cent of those aged 20–24 years, and 4.8 per cent among those aged 25–29 years. Perpetrators are family friends (20.1 per cent), current or former wives/partners (18.0 per cent and 18.7 per cent respectively), and employers or someone at work (11.9 per cent) for those who were ever married. For those who were never married, perpetrators are the survivor's own friends (41.7 per cent), employer or someone at work (18.5 per cent), and family friends (14.2 per cent). For both women and men, sexual violence is experienced as early as 10 years old.[51]

Many international, regional, and national conventions and commitments affirm the importance of targeting adolescents and youth in development initiatives, especially the role of SRHR. These include: the *Beijing Declaration and Platform for Action*[52], the United Nations ICPD Programme of Action[53], SDGs[54], the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa[55], the East African Community Sexual and Reproductive Health Bill 2021[56], the East African Community Reproductive Maternal Newborn Child and Adolescent Health Guideline 2016–2030[57], the Rwanda National Strategy for Transformation (NST1) 2017–2024[58], Rwanda Health Sector Policy[59], and the Rwanda Family Planning and Adolescent Sexual and Reproductive Health Strategic Plan (2018–2024)[60], among others.

Despite the tremendous progress made in terms of supporting adolescents and youth to access knowledge, skills, and services needed for a healthy, productive, and fulfilling life, Rwandan adolescents and youth still face a range of challenges related to their sexual and reproductive health such as unplanned and early pregnancies, unsafe abortions, sexually transmitted infections (STIs) and HIV infections, period poverty and gender-based violence. According to the RDHS 2019–2020, 5 per cent of girls aged 15–19 have begun childbearing, 4 per cent have given birth, and 1 per cent are pregnant with their first child.[61]

The Social Transformation Pillar in the NST1 urges the government to enhance the Demographic Dividend by ensuring access to quality health for all. For adolescents and young people, the focus has been the prevention and fight against drug abuse among youth as well as scaling up efforts to raise awareness on reproductive health and family planning to increase contraceptive prevalence from 48

[51] National Institute of Statistics of Rwanda (NISR), Ministry of Health (MOH), and ICF (2020). Rwanda Demographic and Health Survey 2019–20. Key Indicators Report. Kigali, Rwanda, and Rockville, Maryland, USA: NISR and ICF.
[52] United Nations (1995). Beijing Declaration and Platform for Action. United Nations
[53] United Nations (1994). Population and Development. Programme of Action adopted at the International Conference on Population and Development, Cairo, 5–13 September 1994
[54] United Nations (2015). Transforming our world: the 2030 agenda for sustainable development sustainabledevelopment.un.org A/RES/70/1
[55] African Union (2003). Protocol to the African Charter on human and people's rights on the rights of women in Africa
[56] East African Community (2021). The East African community sexual and reproductive health bill. East African Community Gazette No. 12 of 15th June 2021
[57] East African Community (2016). East African Community integrated reproductive maternal newborn child and adolescent health policy guideline (2016–2030). "Strengthening Regional Cooperation on Women's, Children's and Adolescent's Health in the East African Community"
[58] Government of Rwanda (2017). 7 Years Government Programme: National Strategy for Transformation (NST1) 2017–2024. Kigali
[59] Ministry of Health (2015). Health Sector Policy. Kigali: MoH
[60] Ministry of Health (2018). National Family Planning and Adolescent Sexual and Reproductive Health (FP/ASRH) Strategic Plan (2018–2024). Kigali: MoH
[61] National Institute of Statistics of Rwanda (NISR), Ministry of Health (MOH), and ICF (2020). Rwanda Demographic and Health Survey 2019–20. Key Indicators Report. Kigali, Rwanda, and Rockville, Maryland, USA: NISR and ICF.

per cent (2013/14) to 60 per cent in 2024[62].

2.4 Population dynamics context

According to the recently published Population Census Report (2022), Rwanda counts 13.2 million total population in 2022. The population is young as shown by the age pyramid (Figure 2), reflecting high fertility rates in the recent past. The age-sex structure of the urban population is dominated by adult people in the working age group, a consequence of labour migration from rural to urban areas. This is quite different from the rural population, which reflects the national structure.

The crude birth rate is 27.8 births per 1000 inhabitants. Fertility varies across provinces with the City of Kigali having the lowest total fertility rate (3.0). Eastern provinces have the highest rate (4.0), highest among them is Rusizi (4.5). The mean age at childbearing is 30 years. The crude death rate declined by 63 per cent over a period of 44 years. Infant mortality declined from 144 deaths per 1000 live births in 1978 to 28.9 deaths per 1000 live births in 2022. Under-five mortality also showed a similar pattern of decline.

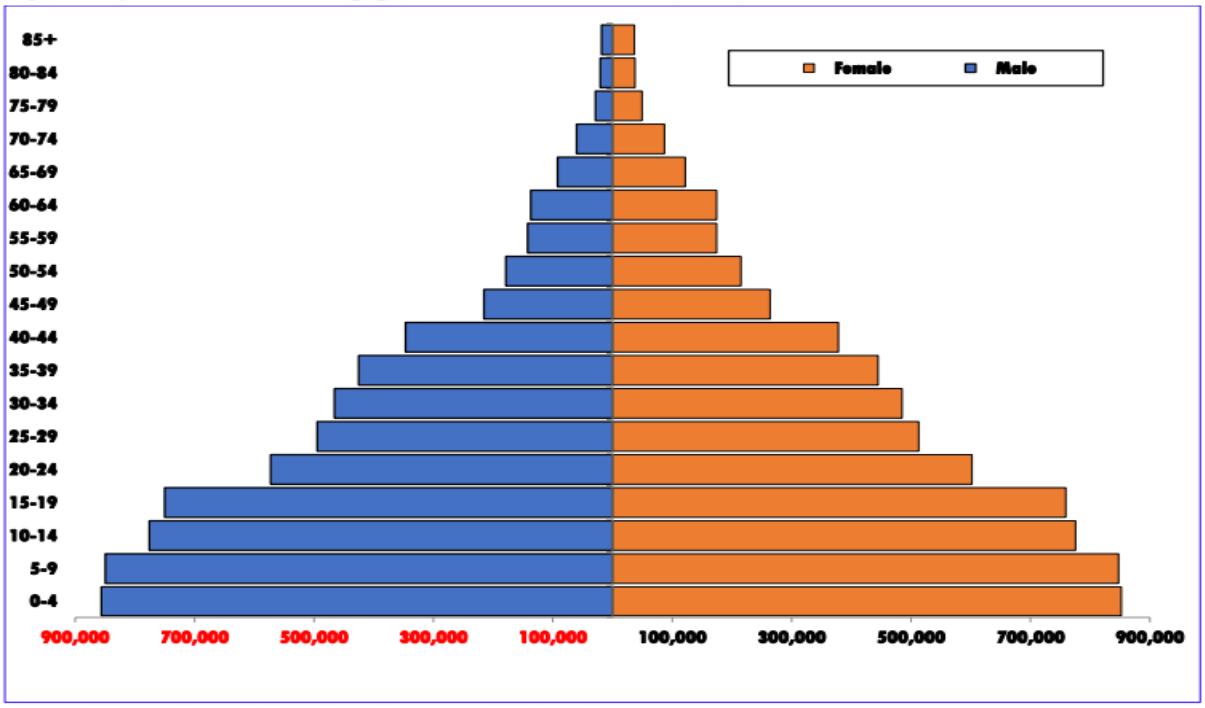
Rwanda has a youthful population, with 65.3 per cent under age 30 and 56 per cent between the ages of 16 and 64 in 2022. The ratio of the urban to rural population indicates that there are approximately three urban residents to every seven rural residents. The city of Kigali is the most urbanized province (86.9 per cent) while the Southern province has the lowest urban population (14.8 per cent). People with disabilities represent 3.4 per cent of the population. The birth rate is 26.4 births per 1000 population and the death rate is 5.86 deaths per 1000 population. Total fertility rate in Rwanda is 3.6 children per woman, showing a decline in the total fertility rate over time from 6.2 children in 1992 to 4.1 in 2019–2020, according to the Rwanda Demographic and Health Survey. Clearly demographic transition is underway in Rwanda.

This significant socioeconomic and health transformation is also seen in life expectancy trends. Life expectancy at birth has increased to 69.6 years (71.2 years for females, 67.7 years for males). There was a decrease in life expectancy at birth between 1991 and 2002, explained by the effect of the 1994 genocide. A subsequent increase was recorded in 2002–2012, a period associated with increased access to health-related services, drinking water, improved housing conditions and other welfare improvements.[63]

Rwanda has the opportunity to reap a demographic dividend and to attain its vision of becoming a middle-income country by 2035, as outlined in the Vision 2050 framework. In the NST1 (2017–2024), the Government committed to harness the demographic dividend by ensuring access to high-quality health and education for all. The country is densely populated, with a population density of around 503 people per square kilometre. Most of the population lives in rural areas (72.1) where agriculture is the primary source of income.

[62] Government of Rwanda (2017). 7 Years Government Programme: National Strategy for Transformation (NST1) 2017–2024. Kigali

[63] Further details on Rwandan Population can be found in NISR (2022).



Source: Fifth Rwanda Population and Housing Census, 2022 (NISR)

Figure 2: Population pyramid of Rwanda

Rwanda has experienced a significant population growth rate over the past few decades, with an average annual rate of population change of 2.3 per cent between 2012 and 2022. This growth rate has slowed in recent years and the country is projected to have a population of around 23.5 million people by 2052 according to the 2022 population and housing census.

In terms of age distribution, Rwanda has a relatively young population. The proportion of the population per age group is as follows: the proportion of young people (below 30 years) dropped from 70.3 per cent in 2012 to 65.3 per cent in 2022 and is expected to be 54.3 per cent by 2050. Those 16–64 age group increased from 53.4 per cent in 2012 to 56.0 per cent in 2022 and is expected to be 61.4 per cent by 2050. People over the age of 65 represent a small proportion of the population at around 4.2 per cent.

2.5 The role of external assistance

Rwanda's development strategy has fuelled economic growth and transformation, reduced dependency on aid and ensured that people living in poverty have benefited from economic growth. It remains, however, the fifth most aid dependent country in the world and is likely to remain aid dependent in the medium term. Poverty levels and economic inequalities remain high and reducing poverty and providing decent employment remains a challenge[64]. International development agencies make the most donations, followed by the United States of America (Figure 2). Table 5 shows that most donations are made to the health and population sectors (35 per cent), followed by other social infrastructures (17 per cent) and economic infrastructures (15 per cent).

[64] Abbot, Pamela and Rwirahira, John (202): Aid effectiveness in Rwanda: Who benefits? Institute of Development Studies, Kigali.

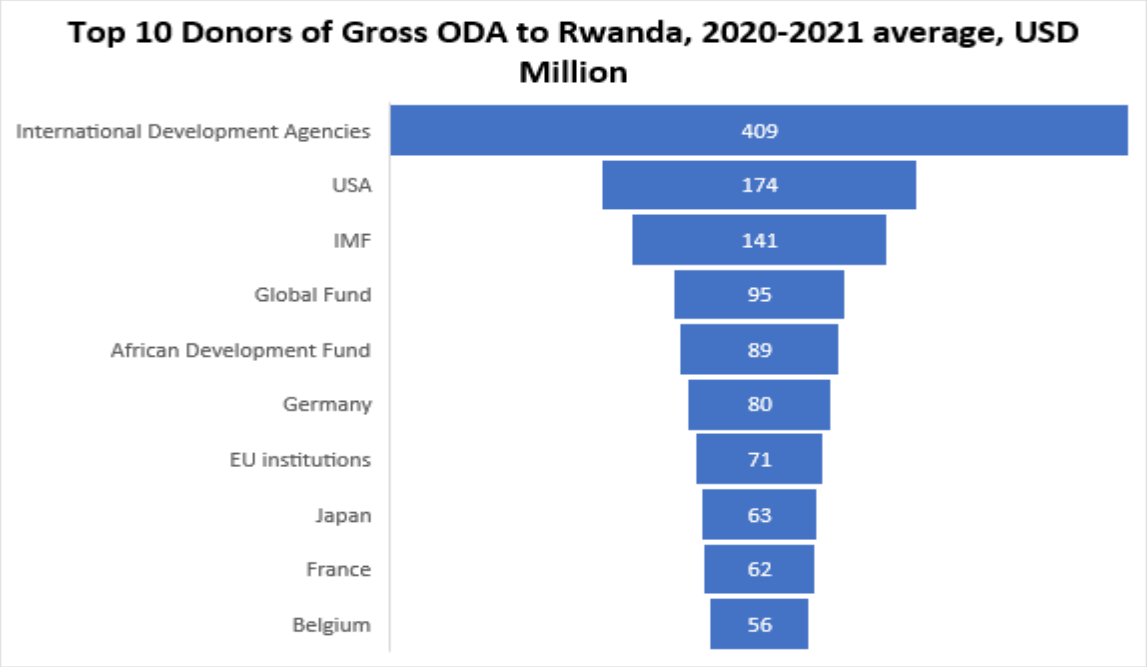


Figure 3: Top ten donors of gross ODA to Rwanda 2020–2021 average [65]

Table 5: Bilateral ODA by sector for Rwanda, 2020–2021 [66]

Bilateral ODA by sector for Rwanda, 2020–2021	
Sector	***ODA***
Multisector	4%
Others and unallocated	5%
Programme assistance	6%
Production	7%
Education	10%
Economic infrastructures	15%
Other social infrastructures	17%
Health and population	35%
Total	***100%***

2.3.1 United Nations Sustainable Development Cooperation Framework

On 1 July 2018, the Government of Rwanda and UNCT launched the UNSDCF for Rwanda. The document outlines joint priorities over a five-year period (2018–2024) in support of national priorities. From 2018–2021, Rwanda had a United Nations Development Assistance Plan equivalent of United Nations Development Assistance Plan (UNDAF), and in 2021 adopted the light UNSDCF which was the basis of a new realignment of the CP. The UNSDCF is aligned with the NST1 and National Economic Recovery Plan in the context of COVID-19. Initiatives articulated in the Cooperation Framework required a total of $631 million, of which $252 million was projected to have been available upon commencement and the remainder $376 million were additional resources that would be mobilized[67].

[65] OECD. Aid at a glance charts. https://www.oecd.org/countries/Rwanda/aid-at-a-glance.htm
[66] Ibid.
[67] United Nations (2018). United Nations Sustainable Development Cooperation Framework (UNSDCF) 2018–2024. Kigali

3. The United Nations and UNFPA response

This section describes the strategic intent of the UNFPA laid out in the strategic plans for 2018–2021 and 2022–2025 as well as UNFPA's intended contribution towards the UNDAP/UNSDCF in Rwanda. It also describes the design of the evaluated Rwanda UNFPA CP along with a brief overview of strategies, goals and achievements of the previous programming cycles.

3.1 United Nations and UNFPA strategic response

Design and implementation of the Rwanda 8th Country Programme 2018–2024 is guided by the UNFPA global Strategic Plans for 2018–2021 and 2022–2025. The 8th CP for Rwanda was initially developed based on the UNFPA strategic plan, 2018–2021 that had four outcomes aligned with General Assembly resolution 70/1 on the 2030 Agenda for Sustainable Development (Agenda 2030) and its 17 development goals. The goal of the Strategic Plan 2018–2021 was to "achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the agenda of the Programme of Action of the ICPD, to improve the lives of women, adolescents, and youth, enabled by population dynamics, human rights, and gender equality". The 8th CP was developed within this framework[68].

The Strategic Plan 2018–2021 also responded to other global frameworks underpinning the 2030 Agenda. These include the Sendai Framework for Disaster Risk Reduction 2015–2030 of the Third United Nations World Conference on Disaster Risk Reduction, the 2015 Paris Agreement on climate change, and the 2015 Addis Ababa Action Agenda of the Third International Conference on Financing for Development. The strategic direction of UNFPA revolves around three transformative and people-centred results. To achieve these results requires strengthened partnerships and innovation, comprehensive policy review, collaboration, and coordination with the United Nations system in Rwanda.

The Strategic Plan 2018–2021 embraces the vision set forth in the 2030 Agenda. Leading up to 2030, UNFPA will organize its work around three transformative and people-centred results: (a) an end to preventable maternal deaths; (b) an end to the unmet need for family planning; and (c) an end to gender-based violence and all harmful practices, including female genital mutilation and child, early and forced marriage.

To achieve these transformative results, the strategic plan emphasizes the need for strengthened partnerships and innovation. It also emphasizes, in accordance with General Assembly resolution 71/243 on the quadrennial comprehensive policy review, stronger collaboration and coordination within the United Nations system, to ensure a coherent, integrated, and effective United Nations response to support countries and communities in achieving the SDGs. In 2022, another Strategic Plan was formulated, SP 2022–2025. A realignment was done but is not reflected in the CP.

The SP 2018–2021 and 2022–2025 adopted the key principles of the 2030 Agenda, including: (a) the protection and promotion of human rights; (b) the prioritization of leaving no one behind and reaching the furthest behind first; (c) strengthening cooperation and complementarity among development, humanitarian action and sustaining peace; (d) reducing risks and vulnerabilities and building resilience; (e) ensuring gender-responsive approaches at all levels of programming; and (f) a commitment to improving accountability, transparency and efficiency.

[68] UNFPA Strategic Plans 2014–2017, 2018–2021 and 2022–2025

Figure 4: Alignment of the "bull's eye" - the goal of the UNFPA Strategic Plan – to the goals and indicators of the 2030 Agenda for Sustainable Development

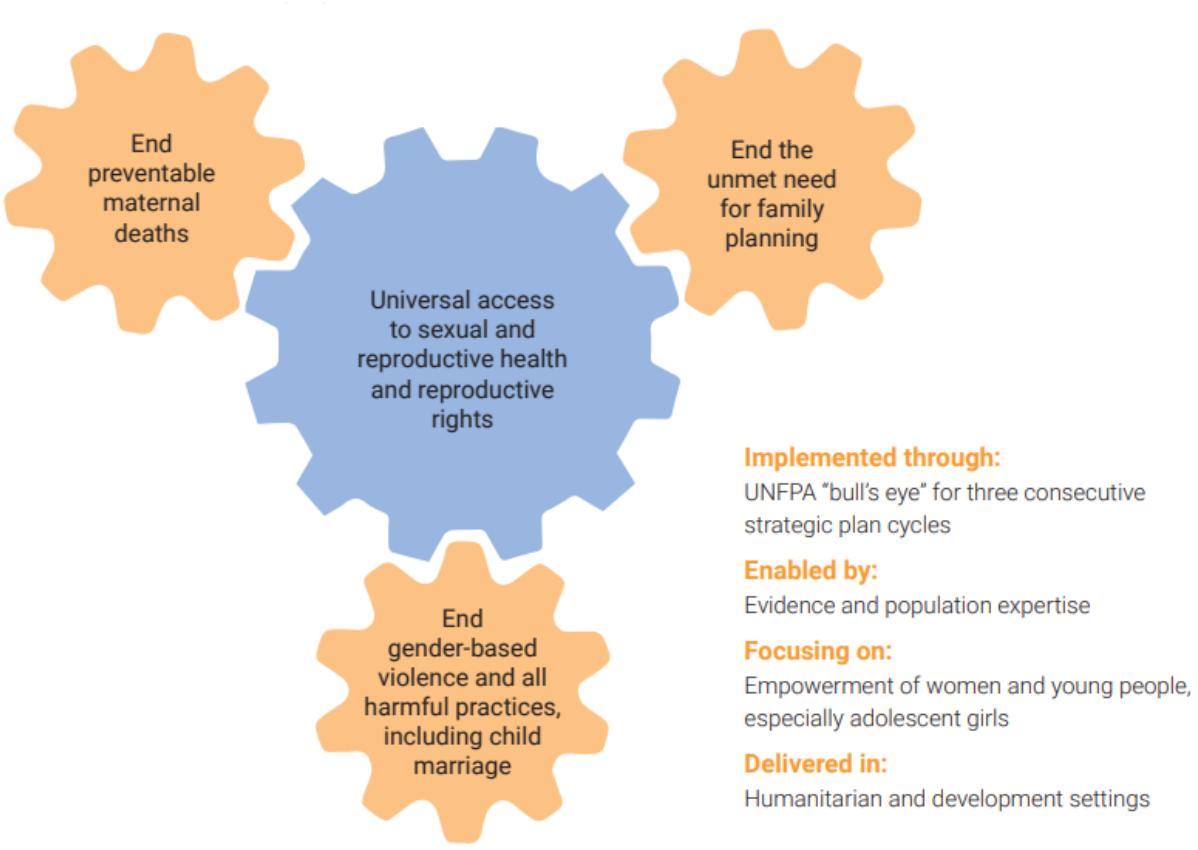


Figure 5: Universal and people-centred transformative results based on the UNFPA Strategic Plan 2022–2025

The use of specific modes of UNFPA operation in a country is linked to a country classification determined by the country's needs and the ability to finance its own development The Strategic Plan 2022–2025 calls for urgent action to achieve universal access to SRH, realize reproductive rights for all and accelerate the implementation of the Programme of Action of the ICPD. This SP, being the second of the three consecutive strategic plans leading to 2030, focuses on pathways and strategies to accelerate the achievement of the transformative results, focusing on how to achieve the three zeros.

In terms of the business model, Rwanda is classified as a Tier One Orange country, meaning its programme focus is on upstream activities. Under this model UNFPA intervention at the country level is operationalized through five modes of engagement listed in Table 6 below).

Table 6: UNFPA business model for Rwanda as a Tier 1 orange country[69]

Modes of engagement	Extent of application in Rwanda
Service delivery	Downstream interventions
Capacity development	The focus is on an enabling environment
Partnerships and coordination, including South-South and triangular cooperation	Deployed
Knowledge management	Deployed
Advocacy, policy dialogue and advice	Deployed

The revised business model is oriented to the needs of Tier 1 Orange quadrant countries. UNFPA is

[69] A Tier 1 country has not achieved any of the three transformative results. To implement the SP 2022–2025, UNFPA would carry out interventions through five modes of engagement listed in Table 6.
UNFPA: UNFPA SP 2022–2025. DP/FPA/2021/8. Annex 3: Business Model

seeking to build national capacities by recognizing the different stages of a country's development and focusing on national priorities. Brokering high-level expertise is critical for providing innovative and integrated policy solutions to achieve impact. The UNFPA South-South and triangular cooperation strategy creates a platform to exchange know-how and support between countries in need and those with deployable expertise. UNFPA human and financial resources must be aligned to this business model. UNFPA COs need strong skills for advocacy and should be receiving technical support from headquarters, regional offices and/or partner organizations.

3.2 UNFPA response through the Country Programme

The strategic plans provide a framework for UNFPA programming. UNFPA interventions are determined by local needs and conditions. Country programmes are at the forefront of implementing the strategic plans. They respond to country needs and priorities, and to the achievement of the SDGs. Country programmes must be aligned with the outcomes and outputs of the strategic plans. UNFPA must address the three outcomes of its strategic plan in an integrated manner, along with the United Nations Development Assistance Programme, renamed United Nations Sustainable Development Cooperation Framework (UNSDCF) 2018–2024.

3.2.1 UNFPA contribution towards UNSDCF in Rwanda

UNFPA, along with other 21 other United Nations agencies working in Rwanda, was actively involved in the development of the UNDAP/UNSDCF and has committed to contribute to the three outcomes within two priority areas (Table 7).

Table 7: UNFPA commitments to implementation of the UNSDCF 2018–2024 in Rwanda

Priority area	Outcomes	Responsible United Nations agencies
1. Social transformation	Outcomes 3 and 4	UNICEF, UNESCO, WO, UNDP, UNFPA
2. Economic transformation	Outcomes 5 and 6	UNDP, UNWOMEN, IOM, UNICEF, WHO, UNESCO, UNFPA

3.2.2 Brief description of the previous strategy, goals and achievements

The 7th Country Programme for Rwanda (2013–2017) was designed to reflect Rwanda's priorities informed by the Vision 2020, Economic Development and Poverty Reduction Strategy, the Millennium Development Goals, ICPD, the Maputo Plan of Action etc. The 7th CP draws from the Common Country Programme Document which focused on three result areas with clearly defined outcomes. UNFPA implemented interventions in line with its strategic framework that focuses on (i) maternal and newborn health, (ii) young people's sexual and reproductive health and sexuality education, and (iii) data availability and analysis. The results and resources framework of the 7th CP was designed around four output areas.

Output 1.1 focused on the capacity of national institutions to conduct research, to ensure informed decision making. To deliver on this output, the UNFPA approach was designed to empower relevant institutions to use high-quality population-based data and enable line ministries to enact gender-sensitive policies taking into consideration community input. **Output 1.5** aimed to expand HIV prevention, treatment, care and support, as well as reproductive health services, among pregnant women, children, youth and key populations. To deliver on this output, UNFPA's approach was to design and support implementation and monitoring of a CSE curriculum for all adolescents and young

people; enhance integration of youth-friendly services; and strengthen comprehensive condom programming at all levels. **Output 2.2** sought to enhance national and subnational capacity to provide quality, integrated health services. To deliver on this output, UNFPA's approach was designed to: empower health providers to deliver high-quality SRH services; ensure health commodity security; bolster the health system response to increased demand; implement a minimum package targeting sex workers and vulnerable populations; and enhance health providers' capacity to address gender-based violence prevention, medical management, and referrals. **Output 2.3** hinged on boosting community demand for high-quality health services. To deliver on this output, UNFPA's approach was designed to strengthen capacity at different levels (district authorities, community leaders and civil society organizations) to implement behaviour change communication interventions and create demand for services.

Among the results, 690 local leaders were sensitized on long-acting contraceptive methods (15 received vasectomy); 3,430 new users were enrolled on FP; 4,792 community health workers were sensitized on preventing maternal deaths and fistula prevention, identification and referral. All indicators for **Output 2.3** showed progress in general. All set targets were achieved except the contraceptive prevalence rate for which Karongi and Ngororero. Under **Output 2.2**, UNFPA procured family planning and SRH commodities worth $4.8 million ensuring SRH and family planning security. UNFPA supported SDP surveys, Rwanda's CHP evaluation, 2015 RDHS and the HSSP III mid-term review. Data generated from these informed the development of the RMNCAH Policy and National Midwifery Action Plan. As a result of UNFPA advocacy, technical and financial input, maternal death audits were institutionalized, 140 health providers were trained on MDA, 419 community health workers were trained on Misoprostol administration, 741,701 couple-years of protection were generated, and 229,409 unintended pregnancies were averted in 2014.

Based on the above results, which show that most performance measures achieved set targets, the UNFPA reproductive health programme successfully contributed to Rwandan couples' ability to choose whether, when, and how many children to have. Therefore, this assessment concludes that UNFPA CP generally achieved its objectives despite a few areas where set targets were missed, marginally[70].

3.2.3 The current UNFPA country programme and analysis of its theory of change

The goal of the 8th Country Programme of Rwanda (July 2018 – June 2024) is to contribute to "universal access to rights-based, gender-sensitive SRH information and services, including for adolescents and young people" as defined in the UNFPA Strategic Plans (2018–2021, 2022–2025). These efforts will be guided by an understanding of population dynamics, human rights, and gender equality, driven by country needs and tailored to the country context to empower and improve the lives of underserved populations, especially women, adolescents, and youth.

The 8th CP in Rwanda is aligned to the following national and United Nations frameworks: NST1 (2017–2024), HSSP IV (2018–2024), UNFPA Strategic Plans (2018–2021, 2022–2025), UNSDCF (2018–2024). There was a realignment of the 8th CP to the UNFPA SP 2022–2025 and UNSDCF due to double transitions from SP 2018–2021 to 2022–2025 and UNDAF to UNSDCF[71]. The 8th CP is largely informed by the mid-term and annual reviews; the end-evaluation of the 7th County Programme (2013–2017), studies, and consultancies by both national and international consultants also provided valuable information for enriching the programme. In compliance with the UNFPA

[70] UNFPA Rwanda 7th Assessment Report 2017
[71] Details of these frameworks can be found in the Rwanda UNSDCF 2018–2024; 2022–2025

guidelines, technical backstopping was provided by the UNFPA Regional Office (ESARO) in Johannesburg.

In addressing the issues raised above, the 8th CP was developed within the framework of the three outcomes of the UNFPA Strategic Plan (2018–2021). Outcome 1 focuses on the SRHR targets of adolescents and youth everywhere, especially those furthest behind, to utilize SRHR services and exercise their reproductive rights, free of coercion, discrimination, and violence. Outcome 2 requires that adolescent girls are empowered to have access to sexual and reproductive health and reproductive rights, in all contexts. Outcome 3 stipulates that everyone is counted and accounted for in the pursuit of sustainable development. These were realigned to the outcomes of the SP 2022–2025[72]. The SP 2022–2025 aims to achieve universal access to SRHR and accelerate the implementation of the ICPD Programme of Action. It contributes to the 2030 Agenda for Sustainable Development while aligning with the 2030 Agenda principles of human rights, universality and leaving no one behind. This will contribute to the achievement of three transformative outcomes namely: zero unmet need for contraception, zero gender-based violence and harmful traditional practices, and zero maternal deaths. These three outcomes are interconnected.

To achieve these three outcomes, the 8th CP interventions were based on four outputs: Outcome 1 (Sexual and Reproductive Health) has two outputs with seven activities; Outcome 2 (Adolescents and Youth) has one output with three activities and Outcome 4 (Population Dynamics) also has one output with four interventions. To achieve the CP goal of achieving universal access to sexual and reproductive health, realizing reproductive rights and reducing maternal mortality to accelerate ICPD agenda, to improve the lives of adolescents, youth, and women, enabled by population dynamics, human rights, and gender equality, the programme would implement upstream interventions focusing on policy dialogue, advocacy, evidence generation, and capacity building at the national level. At the district level, interventions would be through capacity development and service delivery to increase access to youth-friendly SRH services.

Table 8: Strategies selected to achieve the UNFPA Rwanda 8th Country Programme outputs[73]

Outcome 1: Sexual and reproductive health and rights: every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated SRH services and exercised reproductive rights, free of coercion, discrimination and violence.	
Output	Strategies
Output 1: National and subnational institutions have enhanced capacities to develop and implement strategies, guidelines and standards for increased access to information and services on sexual and reproductive health and rights.	▪ support the Ministry of Health to review, develop and disseminate gender-sensitive guidelines to operationalize, at national and district levels, the new strategic plans on adolescent sexual and reproductive health, family planning, gender-based violence, maternal and newborn health, and HIV and sexually transmitted infections prior to the development and implementation of district development strategies; ▪ leverage new information technology, job aids and mobile applications for a cost-effective dissemination of guidelines and tools; ▪ provide technical and financial support to all public and private midwifery schools, to effectively implement a standardized competency-

[72] Ibid
[73] UNFPA Rwanda 8th Country Programme Document

	based midwifery curriculum and increase the number of master trainers in emergency obstetric care; and ▪ advocate for the development and implementation of sustainable financing mechanisms, including a progressive increase of resources allocated to the strategic plans on adolescent sexual and reproductive health, family planning, emergency obstetric care and maternal and newborn health.
Output 2: Advocate for the development and implementation of sustainable financing mechanisms, including a progressive increase of resources allocated to the strategic plans on adolescent sexual and reproductive health, family planning, emergency obstetric care and maternal and newborn health.	▪ building the capacity of the Medical Procurement and Production Division, selected district health facilities and pharmacies in supply chain, data quality management, forecasting and quantification of sexual reproductive health commodities; ▪ scaling up the number of health facilities providing high-quality youth-friendly and gender-based violence services and promoting gender equality across humanitarian sectors; ▪ supporting the implementation of HIV prevention and comprehensive condom programme targeting female sex workers as per the UNAIDS division of labour; ▪ ensuring emergency preparedness and a timely response through prepositioning of lifesaving reproductive health kits; and ▪ improving the quality of pre-service and in-service midwifery training through mentorship, scaling up of the mobile learning system, simulations and the provision of teaching and learning materials. ▪ **Cross-cutting issues**: Gender Equality and Human rights; M and E system, Resource Mobilization, Partnerships, Communications.
Outcome 2: Adolescents and youth: every adolescent and youth in particular adolescent girls is empowered to access to SRHR in all contexts.	
Output 3: Young people, especially young girls, are equipped with knowledge and skills to make informed decisions on reproductive health and reproductive rights and to fully participate in development and humanitarian actions.	▪ expand and improve implementation of CSE for all in-school adolescents; ▪ build the capacity of youth-led organizations and networks to participate in policy making, dialogue on gender equality and implementation of adolescent sexual and reproductive health programmes; ▪ implement community mobilization interventions to enhance acceptance and support from teachers, parents, community and religious leaders for adolescents and youth to use integrated SRH and HIV services; and ▪ foster public-private partnerships and expand partnerships with young people, including in refugee camps, to increase access to and use of innovative information communication technology to improve knowledge about ASRH. ▪ **Cross-cutting issues**: Gender Equality and Human rights; M and E system, Resource

	Mobilisation, Partnerships, Communications.
Outcome 4: Population dynamics: everyone, everywhere is counted and accounted for in the pursuit of sustainable development.	
Output 4: Government institutions at national and subnational levels are better able to generate and use disaggregated data to inform policies and programmes that address inequalities in development and humanitarian settings. UNFPA will use its comparative advantage to support data collection and analysis to identify the most vulnerable populations and prioritize these in advocacy interventions.	▪ providing technical assistance and mobilization of resources to conduct the 2022 Population and Housing Census and the Demographic and Health Survey 2019/2020; ▪ supporting the National Institute of Statistics to improve national data collection systems and technologies to allow for the collection of age, sex and disability disaggregated data at all geographical levels to inform gender-sensitive policymaking; ▪ conducting policy dialogue and advocacy to enhance access to and use of available data for programme monitoring and evaluation; and ▪ advocating and providing technical support for the integration of the demographic dividend study recommendations in national development frameworks, including in sectoral and district development strategies. ▪ **Cross-cutting issues**: Gender Equality and Human rights; M and E system, Resource Mobilization, Partnerships, Communications.

3.2.4 The 8th Country Programme financial structure

Table 9: Indicative assistance by core programme area (in millions of $) [74]

Strategic plan outcome area	Regular resources	Other	Total
Sexual and reproductive health	4.2	5.0	9.2
Adolescents and youth	0.8	1.6	2.4
Population dynamics	1.4	2.5	3.9
Programme coordination and assistance	0.6	0	0.6
Total	7.0	9.1	16.1

The total budget for the Government of Rwanda/UNFPA 8th Country Programme was about $16.1 million, of which $7 million was to be raised from UNFPA core resources while the balance of $9.1 million would be mobilized through co-financing modalities. The SRHR programme area has the largest resource allocation of $9.2 million, followed by population dynamics ($3.9 million), adolescents and youth ($2.4 million), and programme management, coordination and assistance ($600,000).

Through the Strategic Investment Facility (SIF), the implementing partner (Society for Family Health) received additional funding from other partners worth $612,522**,** as follows:

[74] UNFPA Rwanda 8th Country Programme Document

- $25,858 (4.22 per cent) in-kind contribution by Ministry of Health to capacity building and salary for some specialists (dentists and ophthalmologists) at 13 Second Generation Health Posts (Nyagatare 4, Gicumbi 4, Burera 3, Nyaruguru 2)
- $5870 (0.96 per cent) in-kind contribution from Rwanda Medical Supplies Ltd in form of medical supplies for health posts
- $130,994 (21.39 per cent) grant from UNICEF towards capacity building of Health Posts operators, community health workers
- $449,800 (73.43 per cent) grant from African Leadership International Limited towards strengthening health post electronic health records, capacity building and construction of two health posts

Table 10 shows the highest implementation rate was in 2018 (98 per cent), followed by 2020 and 2021 (97 per cent) and 2022 (96 per cent). Overall, there is a 95 per cent implementation rate. Table 11 also shows that the highest implementation rate was on population dynamics programme (99 per cent) ostensibly because of the census, followed by 97 per cent for programme coordination activities and 95 per cent for SRH activities.

Table 10: Budget, expenditure and utilization by year

Year	CORE		NON-CORE		TOTAL		% Used
	Planned	Utilized	Planned	Utilized	Planned	Utilized	
2018	661,079.00	619,776.00	2955006	2933205	3,616,085.00	3,552,981.00	98.25491
2019	1,328,000	1,321,403.06	1451051	938838	2,779,051.00	2,260,241.06	81.3314
2020	1,581,079	1,536,430	2,933,832.98	2,877,447.04	4,514,911.98	4,413,877.04	97.76219
2021	1,347,541	1,310,578	2858841.88	2786671.61	4,206,382.88	4,097,249.61	97.40553
2022	2,810,044	2,770,595	5309142	5032659	8,119,186.00	7,803,254.00	96.10882
TOTAL	7,727,743.00	7,558,782.06	15,507,873.86	14,568,820.65	23,235,616.86	22,127,602.71	95.2314

Table 11: Budget, expenditure and utilization by outcome

Programme	Core		Non-core		Total		% Used
	Planned	Utilized	Planned	Utilized	Planned	Utilized	
SRH	4,140,758	4,049,799	8,679,589	8,197,966	12,820,347	12,247,765	95.5338
A&Y	798,352	762,278	5,327,128	4,886,211	6,125,480	5,648,489	92.213
PD	2,304,257	2,277,267	1,501,156	1,484,644	3,805,413	3,761,911	98.85684
PCA	484,376	468,252	0	0	484,376	468,252	96.67118
Total	7,727,743	7,557,596	15,507,873	14,568,821	23,235,616	22,126,417	95.2263

4. Findings

This section presents answers to evaluation questions under the criteria of relevance, effectiveness, efficiency, sustainability, coordination, connectedness and cross-cutting issues.

4.1 Relevance

Evaluation question 1: To what extent does the UNFPA Rwanda 8th Country Programme align with (i) Rwanda's development priorities and (ii) UNFPA's global strategic plans; and (iii) the needs of the intended beneficiaries, namely women, young people, and vulnerable populations including people with disabilities and key populations? (iv) To what extent has the programme remained relevant and responsive to changing circumstances and varied needs of the population?

Summary: UNFPA country programme (2018–2024) and its three Outcomes (Sexual and Reproductive Health and Rights (SRHR), Adolescents and Youth, and Population Dynamics) were highly relevant to the emergent needs of target populations in Rwanda. The UNFPA Rwanda 8th CP (2018–2024) is based on a clear understanding of the needs and priorities of the Rwandan population and considers government policy frameworks, development strategies for the population. It was relevant to the development needs and priorities of the Government of Rwanda, and needs of intended beneficiaries such as women, adolescents and youth, refugees, marginalized people. It is aligned to the NST1 (2017–2024), the Health Sector Strategic Plan (2018–2024), United Nations Development Action Plan 2018–2023, the SDGs and ICPD Programme of Action, Rwanda Family Planning and Adolescent Sexual and Reproductive Health Strategic Plan (2018–2024), National Youth Council Strategic Plan 2021–2025, and Youth Centre Development Strategy (2020/2021–2024/2025).

Details

4.1.1 Alignment with Rwanda's development priorities

UNFPA supported interventions that are informed by the prevailing national development needs and priorities. Rwanda has established priorities in all development sectors for all categories of the population, including adolescents and youth. Within the broad reflections and initiatives linking the population with the development, the subject of SRHR of young people is mentioned in different conventions, commitments, strategies and surveys at national level, such as the Rwanda National Strategy for Transformation (NST1) 2017–2024, especially Pillar III of social transformation, and the focus of the CP aligns with these strategies. The 8th CP is also in line with HSSP IV (2018–2024), Rwanda Family Planning and Adolescent Sexual and Reproductive Health Strategic Plan (2018–2024), National Youth Council Strategic Plan (2021–2025), and Youth Centre Development Strategy (2020/2021–2024/2025). The adolescents and youth component is aligned to the National Youth Policy, HSSP IV (2018–2024), the policy objectives of the Reproductive Maternal Neonatal Child and Adolescent Health Policy (2017–2030) and to the Ministry of Health Family Planning and Adolescents Sexual and Reproductive Health Strategic Plan 2018–2024. According to document reviews, the Government of Rwanda is committed to achieving the SDGs by 2030 and has declared family planning and ASRH as a national priority for poverty reduction and socioeconomic development of the country (Document reviews and KII).

As further affirmed by a key informant, "*the 8th CP is aligned with government priorities enshrined in the Health Sector Strategic Plan 4… there is an overarching national strategy for transformation that was developed and that provides the vision of the country; there are also SDGs that are localized. So, the different parts of the country programme were really the areas of interventions based on identified national priorities in reduction of preventable maternal death, reduction of unmet need for family planning and the reduction of gender-based violence and other harmful practices; with population*

data as a cross-cutting area of intervention. The 8TH CP aligns with national priorities." [KII).

UNFPA's interventions in Rwanda are designed to align closely with national priorities and policies. This alignment ensures that the interventions are relevant, sustainable, and effective in the local context. The 8th CP aligned with Vision 2020 and NST1. Rwanda's Vision 2020 was a development framework aimed at transforming the country into a middle-income nation by 2020. The NST1 followed this, focusing on economic growth, social welfare, and good governance. UNFPA's programs in Rwanda have been aligned with the goals of these frameworks, particularly in areas related to health, gender equality and youth empowerment. It is also aligned with the Health Sector Strategic Plan. Rwanda's health sector has strategic plans that outline the country's health priorities. UNFPA's interventions in reproductive health, maternal health and family planning have been aligned with these strategic plans, ensuring that they support the government's objectives. Furthermore, recognizing the potential of its young population, Rwanda has prioritized youth empowerment and harnessing the demographic dividend. UNFPA has supported these priorities by implementing youth-focused programs, promoting CSE, and advocating for youth participation in decision-making processes.

Rwanda's commitment to evidence-based policymaking has led to an emphasis on data collection and analysis. UNFPA has supported the NISR by assisting with Population and Health Census 2022 and other demographic surveys, ensuring that the government has accurate data to inform its policies. Given the region's history and potential for humanitarian crises, Rwanda has prioritized emergency preparedness. UNFPA has aligned with this by ensuring that reproductive health services are available even in emergency situations.

The overall goal of these strategic plans is that every Rwandan citizen of reproductive age fully exercises their SRHR and have access to quality services of their choice, thus improving SRH services and enabling an overall increase in contraceptive prevalence (Document reviews and KII). It also seeks to address the underlying causes of unemployment and early marriage and childbearing by adolescent girls and young women who are particularly vulnerable with few opportunities and choices, which is exacerbated by restrictive social and gender norms. (KII, Document reviews).

4.1.2 UNFPA Rwanda 8th Country Programme alignment with UNFPA's global strategic plans

According to a detailed desk review and stakeholder interviews, the 8th CP also aligned with UNFPA Global Strategic Plans. UNFPA is the United Nations agency for reproductive health, whose core mandate is focused on advancing SRHR for adolescents, youth, and the general population. Global UNFPA had two Strategic Plans (2018–2021 and 2022–2025) which were considered for the 8th CP. The goal of the SP 2018–2021 was universal access to SRHR, focusing on women, adolescents and youth, and the general population. The plan sought to ensure that no one would be left behind and that the furthest would be reached first. The SP 2018–2021 responds to other global development frameworks underpinning the 2030 Agenda including the Sendai Framework for Disaster Risk Reduction 2015–2030, the 2015 Paris Agreement on Climate Change, the 2015 Addis Ababa Action Agenda, and the United Nations Development Assistance Plan (UNDAP) II 2018 –2023 (Document reviews).

The SP 2022–2025 was developed in 2022 affirming the relevance of the strategic direction of UNFPA and continuing calls for urgent action to achieve universal access to SRH, realize reproductive rights for all and accelerate the implementation of the ICPD Programme of Action, thereby enabling UNFPA to contribute directly to the 2030 Agenda for SDGs. This SP focuses on

critical pathways and the strategies necessary to accelerate the achievement of the three transformative results, namely i) ending the unmet need for family planning, ii) ending preventable maternal deaths and iii) ending gender-based violence and harmful practices including female genital mutilation, and child, early and forced marriage. The SP, while contributing to advance the ICPD Programme of Action, also concentrates on recovering from the COVID-19 pandemic. The 8th CP particularly is linked with the first three outcomes (Outcome 1, 2, 3). Overall, the Country Programme focused on the core mandate of advancing SRH services for women, adolescents and youth, and marginalized and vulnerable populations.

The 8th CP also contributes to the UNDAP[75] 2018–2024. UNDAP was later renamed UNSDCF[76]. It is also documented and confirmed by all CO key informants that the 8th CP aligns to the SDGs, particularly Goals 3 and 5. The CP in Rwanda had been closely aligned with the priorities/outcomes of the UNSDCF, particularly Outcome 3 which emphasizes improving health outcomes, especially maternal and child health. UNFPA Rwanda's focus on reproductive health, family planning and maternal health directly contributes to these priorities aligning with Outcome 1. The UNSDCF emphasizes evidence-based policymaking, particularly in Outcome 4. UNFPA Rwanda's support for population censuses and demographic surveys contributes to this priority. UNFPA's programs on CSE and youth participation align with the youth empowerment priority in the UNSDCF (Outcomes 2 and 3). UNFPA Rwanda CP focus areas mirror the global mandates and policies of UNFPA, ensuring that the country-specific interventions also contribute to the agency's global goals.

4.1.3 Alignment with the needs of the intended beneficiaries, namely women, young people, and vulnerable populations including people with disabilities and key populations

The 8th CP addressed the national SRH services priorities and needs of the population as planned in the National Health Policy. National survey findings have provided data to rationalize the 8th CP. These included the RDHS 2015, Census of 2015 and various evaluation reports. According to the 8th Country Programme, despite declining maternal mortality ratio, there is a shortage of qualified midwives and master trainers in emergency obstetric and neonatal care (EmONC) etc. These enabled UNFPA CO to develop evidence-based CP which tallied with national needs and priorities stated in the HSSP IV, RMNCAH, National Youth Policy etc.

The 8th Country Programme addressed the national and district level priorities of the population but sometimes there were clashes between district performance contracts, IP focuses and beneficiaries' needs when deciding on interventions, especially in youth support projects and support in computer literacy. The CP and UNFPA's country office annual reports show that the expected outcome of the adolescents and youth component was the empowerment of adolescents and youth to have access to SRHR in the Rwandan context. The RDHS 2019–2020 also showed that 5 per cent of adolescent women aged 15–19 are already mothers or are pregnant with their first child. Although there is an increase in contraceptive prevalence rate, unmet need for family planning was unchanged. Youth-friendly services were limited in scope and coverage. Another need was that despite having a strong data collection system, gaps remain in the availability of disaggregated data especially for the most vulnerable, including adolescents aged 10–14 years and people with disabilities. The use of population data to inform policy formulation, planning, implementation and monitoring remains insufficient both at national and district levels (Document review). UNFPA interventions in refugee

[75] United Nations (2018a). United Nations Development Assistance Plan UNDAP II July 2018 to June 2023 for Rwanda. Kigali.
[76] United Nations (2018b). United Nations Sustainable Development Cooperation Framework (UNSDCF) 2018–2024. Kigali

camps were based on a needs assessment undertaken by the international community led by UNHCR in collaboration with the Government. Relevant needs of the refugee camps were addressed.

4.1.4. Relevance and responsiveness to changing circumstances and varied needs of the population

Key informant and in-depth interviews and document reviews show that the 8th CP was relevant and responsive to the changing circumstances and varied needs of the population. The changing circumstances were especially observed during the COVID-19 pandemic. As people were often prevented from moving freely or gathering face-to-face, online meetings and services and mobile clinics were adopted as alternatives. The time for the disbursement of funds by donors was also affected; some activities were delayed or reprogrammed as a result. Thus, activities such as the wide dissemination of the Family Planning Business Case, the development of the Condom Strategic Plan, and the training of health service providers on the revised HIV Prevention Guidelines were not done in 2020 as planned but postponed to 2021. Other mitigation strategies were mostly employed through IPs including the wide involvement of community-led partnerships, peer-led home visits, and use of community radios. As a result of COVID-19 challenges, UNFPA and its partners built strong resilience to challenging circumstances and made some financial savings through switching to online strategies.

The adaptability and flexibility of the 8th CP was also demonstrated when a new national policy changed the target for antenatal consultations for pregnant women from eight to four visits. The CP was able to support the implementation of the revised policy and guidelines, as well as to the change of beneficiaries' needs.

Overall, the 8th CP and its three outcomes were highly relevant to the emerging needs of the target population in Rwanda. The country has made significant progress in improving maternal health, reducing child mortality and increasing access to reproductive health services. Access to comprehensive SRHR services ensure that women and girls can make informed decisions about their bodies which has implications for their health, education and economic opportunities. As Rwanda continues to evolve, UNFPA's focus on SRHR ensures that services and policies can adapt to these changes (Document reviews, KII). In the case of the adolescents and youth component, the country has a youthful population who need employment opportunities and health services tailored to their needs. The challenges youth face are evolving and by focusing on adolescents and youth, UNFPA ensures that politics and programmes remain relevant to this demographic. Thirdly, with a dense population, understanding and planning for population dynamics is crucial for sustainable development, environmental conservation and ensuring that all Rwandans have access to basic services. Overall, the UNFPA portfolios are entirely consistent with UNFPA policies, strategies, global and national priorities, including the goals of the ICPD Programme of Action and SDGs.

4.2. Effectiveness

Evaluation question 2: To what extent has the 8th CP contributed to (i) increasing access and use of integrated SRH services; (ii) increasing knowledge and skills in young people, particularly girls to make informed decisions about SRHR and fully participate in development and humanitarian actions; (iii) and enhancing generation and use of disaggregated data to inform policies and programmes? (iv) To what extent has UNFPA successfully integrated human rights, gender perspectives and disability inclusion in the country programme?

Summary: UNFPA support has effectively improved the delivery of integrated SRHR services in the intervention districts' health centres. The SRH component of the 8th CP has recorded 100 per cent achievements in both development and humanitarian contexts. The 8th CP has increased access and use of integrated SRH services; as well as knowledge and skills in young people, including young girls to make informed decisions about SRHR and fully participate in development and humanitarian actions. The awareness activities are accompanied by economic support for the most vulnerable youth. UNFPA contributed to improved quality data on population for use in the development and humanitarian contexts. The generation and use of disaggregated data to inform policies and programmes were achieved through the support of the fifth Population and Housing Census conducted in 2022. The targets of all the 12 output indicators were reached. The analysis of the theory of change highlighted that the defined output indicators contribute to the outcome but there is some incoherence and incompleteness between expected results and indicators and lack of robustness in these elements. UNFPA successfully mainstreamed gender equality principles in the 8th CP.

Details

Sexual and reproductive health and rights outcome

There are two outputs for this Outcome in the CP. The Outcome indicators are i) contraceptive prevalence rate and ii) adolescent pregnancy rate, with two main outputs. Output 1 focused on "National and subnational institutions have enhanced capacities to develop and implement strategies, guidelines and standards for increased access to information and services on sexual and reproductive health and reproductive rights". To achieve this output, CO proposed to implement the following strategic interventions:

- Support the Ministry of Health to review, develop and disseminate gender-sensitive guidelines to operationalize, at national and district levels, the new strategic plans on adolescent sexual and reproductive health, family planning, gender-based violence, maternal and newborn health, and HIV and sexually transmitted infections prior to the development and implementation of district development strategies.
- Leverage new information technology, job aids and mobile applications for a cost-effective dissemination of guidelines and tools.
- Provide technical and financial support to all public and private midwifery schools to effectively implement a standardized competency-based midwifery curriculum and increase the number of master trainers in emergency obstetric care; and
- Advocate for the development and implementation of sustainable financing mechanisms, including a progressive increase of resources allocated to the strategic plans on adolescent sexual and reproductive health, family planning, emergency obstetric care and maternal and newborn health.

Output 2 focused on the need to ensure that "National and subnational institutions have enhanced capacities to effectively deliver integrated, youth-friendly SRH services, including for key populations and in humanitarian situations". To achieve this output, CO planned to implement the following strategic interventions:

- Building the capacity of the Medical Procurement and Production Division, selected district health facilities and pharmacies in supply chain, data quality management, forecasting and quantification of sexual reproductive health commodities.
- Scaling up the number of health facilities providing high-quality, youth-friendly and gender-based violence services and promoting gender equality across humanitarian sectors.

- Supporting the implementation of HIV prevention and a comprehensive condom programme targeting female sex workers as per the UNAIDS division of labour.
- Ensuring emergency preparedness and a timely response through positioning of lifesaving reproductive health kits; and
- Improving the quality of pre-service and in-service midwifery training through mentorship, scaling up of the mobile learning system, simulations and the provision of teaching and learning materials.

Document reviews, key informants, in-depth interviews and site observations revealed that through several activities in partnership with the Ministry of Health, University of Rwanda and development partners, UNFPA works to ensure that every childbirth is safe, and create an environment where midwives provide quality health services towards achieving zero preventable maternal deaths and zero unmet need for family planning. According to findings from the 5th Rwanda Population and Housing census, Rwanda has made great progress in reducing maternal mortality over the last decade from 487 to 203 deaths per 100,000 live births. UNFPA, in partnership with IPs, established midwifery faculty to enhance the quality of midwifery education for 328 annual midwifery students and provide evidence in the area of RMNCAH. Some 630 nursing students in seven newly established schools benefited from simulation laboratory equipment procured by UNFPA. More than 377,000 clients were provided with health care services through 31 second-generation health posts established in 10 districts with the support of UNFPA. Through the One UN Joint Programme, UNFPA upgraded 31 second-generation health posts financed with catalytic start-up funds and supported the transition from grant dependency to financial self-sustainability. The health posts have not only increased access to health care but also created more than 300 jobs, of which 60 per cent are occupied by women.

Document reviews show that UNFPA contributed to the launch of Rwanda's first Master of Science (MSc) in Midwifery through the provision of scholarships for master's students and PhD candidates. This will equip midwives with knowledge to save the lives of mothers and newborns. The Associate Nursing Programme in upper-secondary level education was equipped with simulation laboratory equipment which will provide 630 nursing students with quality education through simulation-based training.

Further document review and stakeholder interviews revealed that UNFPA supported the financing of private health care centre to save lives through public-private community partnerships. Under the joint United Nations SDG programme "1000 Health Posts"[77], UNFPA as the lead is piloting Public-Private-Community Partnership to make health posts functional. Thirty-one second-generation health posts (SGHPs) located in five districts (Gicumbi, Burera, Nyaruguru, Nyagatare and Rusizi) were made fully functional and able to provide health services to more than 132,654 clients in the hardest to reach areas. As a result, 461 women delivered at the health posts and 2,571 women became new users of modern family planning methods. Eighty-nine health-care providers were trained in reproductive, maternal, newborn and child health services, and 180 decent jobs were created through the programme (Document reviews, KII and IDI).

The 8th CP contributed to reducing maternal and child mortality, preventing unintended pregnancies and STIs, empowering youth, addressing gender-based violence, and advancing gender equality[78].

[77] This is a project being implemented under One UN Joint Programme on Health through the Strategic Investment Facility.
[78] UNFPA Rwanda Country Programme document

To improve the quality of maternal and newborn health care, UNFPA Rwanda launched MobiMentor, a mobile initiative with structured simulation equipment that facilitates a capacity-building model which allows training packages to be tailored to the specific needs of targeted health facilities. Through this innovative mentorship program, 81 health care providers were trained to improve service delivery at health-care facilities. Continuous on-the-job mentoring will lead to long-term improvements in the health sector and will bridge gaps in EmONC, family planning and comprehensive abortion care (Document reviews, KII and IDI).

UNFPA CO also supported innovation in midwifery through digital technology and policy. Document reviews showed that UNFPA supported the Rwanda National Council of Nurses and Midwives to develop and launch a web-based application that facilitates license applications, continuous professional development, and monitoring the mobility of nurses and midwives (Document reviews; KII). This application will increase the managerial capacity of the council to better collect and analyse data on human resources for health and increase evidence-based planning towards achieving equity in deployment.

UNFPA also supported the expansion of a mobile learning system in 26 new health facilities across the districts of Karongi and Rutsiro to ensure smooth transfer of midwifery knowledge and skills in a sustainable manner. This portable learning tool is an innovative approach to improving access to quality training for midwives and health workers in remote, low-resourced settings with poor internet connectivity and a lack of trained tutors, thereby improving health outcomes in communities. UNFPA partnered with ENABEL (the Belgian Development Cooperation Agency) to support Ministry of Health to conduct the EmONC assessment. UNFPA strengthened partnership with Rwanda Biomedical Centre and health profession associations to scale up on-site mentorship on EmONC across health facilities. Document reviews and key informant interviews show that the quality of EmONC services has been improved through this UNFPA-supported mentorship programme,.

Sixty-one health facilities were supported and more than 100 health care providers were validated on EmONC competencies. UNFPA also supported mentorship on family planning to enhance the quality of services and address staff turnover and the shortage of family planning competencies. Ten districts were supported and an average of 100 health facilities were reached by district-based mentors each month. As a result of the mentorship support, family planning services are now organized in all supported health facilities, each with a designated family planning focal point. Materials, job aids and tools have been provided for the service, and at least two health-care providers in each health facility have been validated to offer all family planning competencies.

The mentorship programme ensured more than 100 health providers in 61 health facilities validated on EmONC competencies. This mentorship programme enabled the transfer of knowledge and skills in a friendly and efficient manner through continuous on-site-mentorship. However, while the mentorship approach is efficient, it requires strong support especially at the beginning to ensure quality and establish a strong monitoring system to track improvement in quality of care across health facilities. It is expected that continuous quality improvement of EmONC service delivery will contribute to further reducing preventable maternal and neonatal deaths and increase universal access to quality integrated SRH services.

Rwanda Midwifery Association was supported to reduce preventable maternal and neonatal morbidity and mortality by improving midwifery skills of the in-service and pre-service midwives using hands-on training through simulations. Thus far, 16 facilitators were trained in all modules, 67 were trained

in helping babies survive, 61 were trained on pre-eclampsia/eclampsia and 63 were trained in bleeding after birth complete. UNFPA supported this project with 21 anatomical models (MamaNatalie and accessories) using the donation from the Laerdal company (Document reviews; SIS and Country Office Annual Report).

UNFPA played a pivotal role in advancing maternal and neonatal health care through a comprehensive set of initiatives. This included supporting the development of new World Health Organization (WHO) guidelines for antenatal care with a minimum of eight contacts during pregnancy, as well as crafting guidelines and implementation protocols for EmONC, safe abortion, and post-abortion care. Simultaneously, UNFPA spearheaded the creation of new electronic medical records, seamlessly integrating reproductive, maternal, newborn, child, and adolescent health services. The organization also elevated the existing rapid SMS system to an improved RapidPro system, ensuring real-time health data for effective programme monitoring through document reviews and Key Informant Interviews (KII).

These integrated activities were specifically designed to ensure continuous quality improvement in EmONC service delivery, ultimately contributing to the reduction of preventable maternal and neonatal deaths. The overarching goal was to increase universal access to high-quality, integrated SRH services. Furthermore, UNFPA facilitated mentorship programs on EmONC for 59 health-care providers and disseminated the new WHO antenatal care guidelines. This concerted effort is anticipated to significantly enhance the quality of maternal and neonatal health services, fostering a positive health-care experience for pregnant mothers.

UNFPA provided Technical Assistance to the Ministry of Health through deployment of an international UNV Midwife to support maternity services in Muhima, the district hospital with busiest maternity ward in the country.

UNFPA supported interventions to strengthen the capacity of midwifery teaching institutions through capacity building for faculty members and students in implementation of midwifery competency-based academic curriculum. This enables training institutions to produce skilled and competent midwives ready to save the lives of mothers and newborns (Document reviews). Further desk reviews and key informant interviews revealed that UNFPA contributed to improved quality of education in midwifery through revision of clinical tools used in mentorship and competency-based midwifery curriculum in various clinical placements. The quality of supervision and mentorship conducted by midwifery tutors in various clinical placements was improved by a refresher capacity building workshop of 95 tutors on EmONC. In addition, UNFPA supported midwifery schools with 21 anatomic models (MamaNatalie and NeoNatalie and its accessories) to equip the skills lab and facilitate learning through simulations. These interventions will help midwifery schools to improve quality of education and enable them to produce skilled and competent midwives.

Through partnership with the University of Rwanda and ICM, UNFPA supported 129 midwifery graduates to increase their capacities and competences through training and certification in the Helping Mother Survive (HMS) and Helping Baby Survive (HBS) modules aimed at reducing preventable maternal deaths in Rwanda to zero. This will improve the graduates' knowledge and skills and will enable them to lecture in the first Master of Science in Midwifery at the University of Rwanda which was launched in May 2023. UNFPA supported the continuous supervision of clinical placements to ensure a smooth transfer of midwifery skills through clinical clerkship (Document reviews, KII and IDI).

UNFPA partnered with the University of Rwanda School of Nursing and Midwifery to strengthen the capacity of the midwifery department to implement a competency-based curriculum aligned with the 2018 ICM/WHO standards. UNFPA supported the launch of the new Master of Science in Midwifery through provision of scholarships and laptops to support five midwifery tutors to pursue studies at Masters level and at one at PhD level.

Advocacy and policy dialogue

Document reviews and stakeholder interviews revealed that UNFPA supported advocacy initiatives under the 8th CP. UNFPA financed the development of a web-based application for the Rwanda National Council of Nurses and Midwives to enable the council to provide a platform for license application, continuous professional development, monitoring the mobility of nurses and midwives among others. This will increase the managerial capacity of the Council to better collect and analyse data on human resources for health and increase evidence-based planning towards achieving equity in deployment. Better human resource management will have a positive impact on maternal and child morbidity and mortality, especially in remote areas. Furthermore, UNFPA supported the Council to validate professional Standards of Practice for Nursing and Midwifery in Rwanda, which will help protect both patients and health practitioners, as well as ensure quality of care across the health care continuum. (Document reviews).

UNFPA sponsored three board members of the Rwanda Association of Midwives in the ICM Regional Conference for Africa where they presented three abstracts on best practices of midwifery in Rwanda. During the conference, the UNFPA programme officer for maternal health and midwifery presented two abstracts focusing on the implementation of a mobile learning system and e-learning within health facilities and training institutions in Rwanda. This initiative significantly bolstered RAM's capacity to generate, share and utilize research evidence and data for advocacy purposes. The Association gained valuable insights into global midwifery programming and best practices, including the pivotal role of young midwifery leaders in advocacy efforts. Equipped with enhanced knowledge and skills, RAM successfully spearheaded the data collection for the State of the World's Midwifery Report 2021, leading the process from inception to completion.

Moreover, the promotion of the midwifery profession was actively pursued through diverse events, notably the commemoration of the International Day of Midwives, with the participation of 350 midwives, faculty members, development partners and government officials. Beyond celebrating the accomplishments of the midwifery profession in Rwanda, this gathering served as a platform to showcase the progress of midwifery in championing women's rights, particularly in ensuring the right to safe motherhood. The event facilitated screenings for breast cancer, counselling sessions, and the provision of family planning services, benefitting 80 participants. UNFPA played a pivotal role in mobilizing additional partners, leading to a 50:50 co-financing arrangement between ICM and UNFPA for the International Day of Midwives celebration. Furthermore, UNFPA actively supported the training and certification of 27 health providers stationed in clinical placement sites for midwifery students across the country. These collective efforts, as mentioned earlier, significantly contributed to enhancing respectful maternity care delivered by skilled midwives, aligning with the pursuit of the SDGs (Document reviews, KII).

Another aspect of the 8th CP interventions is investment in tracking maternal deaths together with other partners in the country to support the Ministry of Health. UNFPA supported the first

confidential enquiries into maternal and perinatal deaths to improve the quality of maternal death reviews. This revealed the prevailing factors and causes of preventable maternal and neonatal deaths enabling decision makers to design and implement systematic solutions and interventions for improvement. UNFPA provided technical assistance through the national Maternal Death Surveillance and Response committee workshop to carry out a thorough analysis of maternal and neonatal death review reports for quality assurance purposes. This workshop produced an action plan and formulated recommendations that were submitted to concerned stakeholders including the Ministry of Health.

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UNFPA provided technical support to finalize the national guidelines to end fistula in Rwanda. This addendum to the MNCH strategic plan 2018–2024 is currently waiting to be signed by the government. Once launched, the guidelines are expected to increase both stakeholders' focus on fistula service provision as well as government's expectations of partners' support. Meanwhile UNFPA supported the revision of screening and notification tools and built the capacity of 23 health providers to lead the implementation across their respective health facilities (Document reviews).

Overall, there were many upstream interventions implemented by the CO. UNFPA enabled the Government to make commitments on ICPD25, committing to increase domestic budgetary allocation for health; to ensure that the necessary legislative policy and strategic frameworks which provide for all persons to have access to quality integrated SRH services etc. UNFPA CO supported the Government to take part in the five-year review of the Addis Ababa Declaration on Population and Development. Rwanda has subsequently fully integrated the Declaration into its national development framework. The commitments are reflected in the constitution, laws, policies and strategies at different levels. UNFPA also supported a technical preparatory workshop toward the high-level Rwanda ICPD25 commitments.

The Government of Rwanda, with financial and technical assistance from UNFPA, has crafted the inaugural integrated RMNCAH policy. This policy is a response to the evolving global health agenda, aiming to ensure that the rights of women, newborns, children and adolescents are realized in terms of the highest attainable standards of health and well-being, enabling them to reach their full potential. Aligned with national frameworks such as Vision 2020 and the guiding principles of the Rwanda Health Sector Policy, the RMNCAH policy offers a comprehensive overview of the current SRHR landscape in Rwanda. It establishes a framework for policy objectives and governance, maintaining consistency with existing national policies and strategies. Alongside the development of the RMNCAH policy, UNFPA has supported the formulation of a costed Family Planning/Adolescent Sexual Reproductive Health (FP/ASRH) Strategic Plan and a Maternal Neonatal Child Health (MNCH) Strategic Plan. UNFPA also facilitated the development of the HSSP IV (2018–2024).

UNFPA played a crucial role in supporting the Ministry of Health with the organization of the 2018 International Conference on Family Planning, held in Kigali 12–15 November. UNFPA and in-country partners capitalized on this opportunity to advocate for a move towards national ownership of the family planning programme and pushed to address existing legal barriers. The conference helped create a conducive environment for accelerating the family planning agenda in Rwanda and led to a vote on a law to enable adolescents to receive reproductive health services without parental consent. More specifically, development partners requested changes with regards to two articles.

UNFPA played a crucial role in engaging with the government to create a comprehensive policy framework that recognizes family planning as a catalyst for sustainable economic growth and progress

towards the SDGs. Following a meeting with development partners and sustained advocacy efforts by UNFPA, the Ministry of Finance commissioned UNFPA and USAID to develop a family planning business case to provide a clear and up-to-date analysis of family planning services needs and gaps and plans for financial sustainability through domestic financing. The business case was finalized and disseminated at the central level involving Government institutions, development partners, civil society organizations, local leaders and religious leaders. This resulted in deliberation of key recommendations to increase financial resources allocated to family planning in high-level advocacy meetings at Rwanda Parliament.

The UNFPA Rwanda CO has consistently led the charge in catalysing positive transformation and spearheading initiatives that have paved the way for the Government's active participation in international commitments like the United Nations Global Compact and Family Planning 2030 (FP2030) commitment. The groundwork for this success was laid by fostering an enabling environment through well-informed policies and strategies that align seamlessly with the global FP2030 objectives. Notable policies include those related to RMNCAH, strategic plans, the school health policy, the CSE national reference, the HIV operational plan, and HIV/SRH guidelines, among others. UNFPA's tireless advocacy, technical expertise and financial support have played instrumental roles in the development and effective implementation of these policies.

UNFPA's support has led to the generation of substantial evidence, including new Census data, RDHS, and various studies and assessments that have contributed to the tailoring of impactful programs. Notably, UNFPA pressed for the Government to increase domestic resources for family planning. This effort was underscored by the development of a Family Planning Business Case that illuminated the benefits of investing in family planning across all sectors. The compelling evidence presented in this case spurred the Ministry of Health to prioritize domestic investment, resulting in a remarkable increase of more than 10 per cent in domestic funding for family planning commodities within just one year, from 2021 to 2022. This achievement stands as a testament to the commitments made under the Compact and FP2030.

Furthermore, UNFPA has adopted a holistic approach by providing invaluable technical and financial support to bolster Rwanda's initiatives in family planning, maternal health and gender equality. The office has played a pivotal role in strengthening the nation's health-care system, ensuring a consistent supply of contraceptives, and enhancing health-care infrastructure. As a result of these concerted efforts, Rwanda's dedication to family planning and reproductive health has not only been sustained but has also flourished, evidenced by a noticeable increase in contraceptive prevalence rates and a substantial reduction in unmet need for family planning, as well as a decrease in maternal mortality rates. The UNFPA Rwanda CO continues to expand partnership for collaboration and innovation with a particular focus on harnessing the potential of young people. This remarkable partnership demonstrated how international collaborations can foster sustainable development and significantly improve the lives of a country's people.

Family planning commodities

With UNFPA supplies partnership, family planning commodities and life-saving medicines worth more than $15 million since 2018 led to an average of 750,701 couple-years of protection from unintended pregnancies annually. UNFPA strengthened the capacity of health-care providers for quality family planning services. UNFPA supported the Ministry of Health to implement key high-impact interventions to boost uptake and address the unmet need for family planning. This includes support to postpartum family planning and post-abortion care, the introduction of new methods and

community engagement, among other initiatives. To implement this, in addition to procuring commodities and permanent methods kits, UNFPA Rwanda CO also supported in coordination of partners for synergy and effective use of resources. It also invested in building the skills of medical doctors, nurses/midwives and community health workers to provide permanent, long- and short-acting contraceptive methods. This enabled a quick scale-up of high-impact practices as mentioned above. Records show that 926 health care providers were trained in 2022 only to provide long- and short-acting methods including hormonal IUD, the DMPA-SC injectable, and emergency contraceptives among other family planning methods. Capacity building is coupled with demand-generation efforts and integrated outreach services that include family planning, cervical and breast cancer screening, and other services, reaching those who are furthest behind in remote areas of health facilities. This contributed to an increase of 5 per cent of family planning users, 60 per cent increase for DMPA-SC and over 40 per cent increase for hormonal IUDs compared to the previous year (Document reviews, IDI). Moreover 4,365 community health workers were trained through roll out of a competency-based polyvalent model composed of 14 competencies (Document review). More than 1,8 million new users for modern contraceptives were recorded in 2022 which averted 122,000 maternal deaths and 910 unsafe abortions.

The Government has committed to managing the population through increasing the uptake of contraceptives and reducing fertility levels as documented in the Economic Development and Poverty Reduction Strategy (2018–2024) and national Strategy for Transformation. It aims to achieve this through a sustained campaign on voluntary family planning, increasing the uptake of (modern) contraceptive methods for both men and women, and improving the living conditions of Rwandans through universal access to health and basic education. In partnership with the Ministry of Health and ENABEL, the Business Case for Family Planning in Rwanda was developed to uncover the return on investment for every dollar spent on Rwanda's family planning programme. It was found that every $1 invested in family planning could yield $112 in returns or savings benefitting many sectors. The savings can be used to finance other development activities within or between sectors in Rwanda. The health sector's benefits (over 48 per cent) are the greatest. Education (28 per cent) and the economy (20 per cent) will also make substantial savings by investing in family planning.

UNFPA supported several interventions to improve quality care in family planning services as well as demand creation. UNFPA, in collaboration with Ministry of Health/ Rwanda Biomedical Centre, Imbuto Foundation and other partners, supported national Maternal Child Health week and its flagship campaign BAHONEZA. Through this campaign, combined with sensitization and service provision, 35,803 new users of family planning were enrolled. UNFPA and the Governments of Canada and Rwanda co-hosted the launch of the third phase of the UNFPA Supplies Partnership 2021–2030, paving the way for a new decade of commitment to advancing family planning and maternal health and accelerating progress towards the SDGs. (Document reviews, KII and IDI).

Document review showed that based on the 2022 Service Delivery Point (SDP) Survey, all primary service delivery points provided a minimum of three modern family planning methods in accordance with national protocols, guidelines and regulations. Additionally, 98.8 per cent of them offered at least five modern family planning methods. The survey also found an upward trend in the occurrence of no stock-outs of modern contraceptives, excluding female condoms and private facilities, rising from 47 per cent in 2018 to 66 per cent in 2020 and 76 per cent in 2022. Site visits to health centres and interviews with midwives and health workers confirmed there was no family planning stock-out in the health centres visited while adolescents and other beneficiaries did not report of lack of any family planning commodities (Document reviews, KII and IDI). These various activities were

implemented diligently by the CO. It is expected that the cumulative results will contribute significantly to improvement in maternal health, leading to a reduction in maternal mortality, and possibly contribute to the achievement of zero maternal mortality. All SRHR activities have contributed to reduction in maternal mortality, increase in family planning and reducing gender-based violence by promoting change in attitudes and behaviour to gender-based violence.

Adolescents and youth outcome

Country Programme interventions in Adolescents and Youth fall under Output 3 which states "Young people, especially young girls, are equipped with knowledge and skills to make informed decisions on reproductive health and reproductive rights and to fully participate in development and humanitarian actions**".** To achieve this output, CO implemented the following strategic interventions:

- expand and improve implementation of CSE for all in-school adolescents.
- Build the capacity of youth-led organizations and networks to participate in policy making, dialogue on gender equality and implementation of adolescent sexual and reproductive health programmes.
- Implement community mobilization interventions to enhance acceptance and support from teachers, parents, community and religious leaders for adolescents and youth to use integrated sexual and reproductive health and HIV services; and
- Foster public-private partnerships and expand partnerships with young people, including in refugee camps, to increase access to and use of innovative information communication technology to improve knowledge about adolescent sexual and reproductive health.

For the adolescents and youth component interventions, the achievements include the establishment of functioning youth corners and health centres in refugee camps and the functioning youth centres and Youth Empowerment for Global Opportunity (YEGO) centres at the sector and district levels respectively. These are youth-friendly spaces where the adolescents and youth can access vital services and information about sexuality, which has historically been taboo in the country. In these facilities, adolescents and youth can receive private counselling, access information on family planning, safe sex practices and sexual health via various media including video and discuss it with peers and peer educators. They can also access testing for STIs and circumcision. UNFPA has established functioning youth corners in all five refugee camps in Rwanda (Mahama, Kiziba, Kigeme, Nyabiheke, and Mugombwa). Another 30) youth corners in the three targeted districts (Nyamasheke, Karongi, Rusizi) are equipped with IEC materials and equipment (Document review, IDI, Site Visits).

The services provided in youth-friendly facilities are coupled with socioeconomic support to the most vulnerable out-of-school adolescents and youth to increase their resilience and independence. Doing so can significantly reduce unwanted pregnancies and the spread of STIs. Young women are supported in small businesses, domestic animal rearing (pigs and goats), vocational activities (tailoring), horticulture (mushroom production), etc through training, financial assistance for start-up materials and equipment, basic infrastructure, marketing where necessary, follow up, management advice, etc. At the time of this CPE, 4,380 young mothers and youth with disabilities had benefited from this intervention (Document review, FGD, IDI).

Successful ASRH programming requires that young people can express their views to decision-makers. Thus, UNFPA CO supported youth-led organizations and networks to participate in policymaking and dialogue around the implementation of ASRH programmes. UNFPA has supported

21 youth-led organizations under the umbrella of African Youth and Adolescents Network (AfriYAN) through capacity building of the network. Through AfriYAN, 3,500 youth were trained on youth leadership and advocacy for ASRH. Another training was organised on SRHR and advocacy, attended by 58 young people. Members of AfriYAN were trained in advocacy, supported in mapping other youth-led organizations, and in participating in SRH policy dialogue. UNFPA built the capacity of AfriYAN in other ways that include financing its general assembly, dissemination of a youth communiqué, and production of quarterly newsletter. (Document review). This support has enabled these organizations to take part in Government working groups. AfriYAN was also able to write a policy paper on age limits required to access ASRH information and services without parental consent, which was ultimately supported by the Prime Minister's Office[79] (Document reviews and FGD).

Comprehensive Sexual Education has been implemented in 100 public schools following its integration into the national school curricula in 2016. During this cycle, about 3110 booklets[80] were produced and distributed to in- and out-of-schools adolescents, and Rwanda Education Board (REB) was supported financially to implement these activities. More than 1807 teachers from six districts (Bugesera, Kayonza, Burera, Musanze, Nyamasheke and Karongi) were trained in CSE as well as other 81 master trainers. In addition, 12,756 out-of-school youth were identified and equipped with knowledge in ASRH. At the time of CPE, more than 5000 teachers were capacitated on CSE through online and face-to-face training, and more than 41 school-based clubs were functioning. However, the overall capacity of educational staff in CSE seems appears to be low according to the 2021/2022 Education Statistical Yearbook, educational staff in Rwanda were 125,621 of whom 92,665 were teaching staff in primary, secondary, and TVET (L1 to L5) levels[81]. There is still much to do to ensure that CSE is extended to all schools in the country. Unfortunately, the evaluation team did not have a chance to contact schools and school staff to explore this matter in more depth (Document reviews, IDI, KII).

4.2.1 Increasing knowledge and skills in young people, particularly girls, to make informed decisions about SRHR and fully participate in development and humanitarian actions

Document reviews, key informant and in-depth interviews show that UNFPA-supported interventions to increase knowledge and skills of young people were promoted through several strategies. Peer educators worked in the community and refugee camps They were equipped to train other youth, distribute condoms, provide advice on SRH and STIs, and refer to youth health centres. More than 37,489 adolescents and young people aged 10–24 years accessed ASRH information services in refugee settings exceeding the target of 30,000 people (Document review, KII, IDI).

UNFPA supported the use of school entertainment (edutainment) to spread the message of SRHR, through the establishment of School Health Clubs. Adolescents, and youth members of 150 school-based health clubs were trained on sexual and reproductive health, gender-based violence and menstrual health. Religious leaders were also trained to convey SRH messages to young people. Sermons and messages rooted in the Holy Scriptures (Quran, Bible) on SRH (and maternal health) were developed. Some 285 out of 600 (47.5 per cent) targeted religious and community leaders

[79] UNFPA (2019). 2018 Annual Report – Rwanda. Kigali.
[80] The two booklets are (i) CSE and youth-friendly health services in Rwanda, which is an information booklet for young people 10–19, peer educators and Youth counsellors; and (ii) CSE Information Booklet: How CSE supports a better, healthier future.
[81] MINEDUC (2023). 2021/22 Education Statistical Yearbook. School year ended in July 2022. Kigali.

participated in ASRH policy dialogue at the national and subnational level. Other channels such as radio and television were also used to reach millions of people, including youth (Document reviews; KII).

This messaging has yielded important results. Young mothers report that those who engaged with UNFPA's implementing partners did not have second births due to increased knowledge and awareness, and greater availability and use of established facilities and services. During a focus group discussion in a refugee camp, one young mother (and peer educator) said: *"All of us have opted for family planning when our children were still small. We now know how to care for our kids and have decided not to get pregnant again." [FGD, IDI).* Similar views were recorded in other districts and evaluation reports. (Document review).

Around 1,062,500 adolescents and young people aged 10–24 years were reached with adolescent sexual and reproductive health and gender-based violence prevention messages through outreach campaigns and intergenerational dialogues funded by UNFPA support. In the five camps (Kiziba, Mugombwa, Mahama, Kigeme, Nyabiheke), 67,067 adolescents and young people aged 10 – 24 years were able to access adolescent sexual reproductive health and gender-based violence information and services. More than 500 local leaders and gender-based local support structures received awareness sessions to challenge gender discriminatory attitudes and practices and subsequently committed to support UNFPA efforts to advance rights for all and reduce inequalities in access to SRH services (Document reviews). It is important to research whether this results in any change in attitudes and behaviours around gender-based violence.

In partnership with the Government of Rwanda, through the Ministry of Health, Ministry of Youth and Culture, Ministry of Education, Ministry of Emergency Management, and with funding support from KOICA, UNFPA implemented a three-year project named "The Healthy and Empowered Youth." The project was implemented in three districts (Rusizi, Karongi, and Nyamasheke) and six refugee camps (Mahama, Kigeme, Mugombwa, Kiziba, Gihembe, Nyabiheke) and their host communities, with the aim of empowering adolescents and youth to realize their human right to equality, sexual and reproductive health, and freedom from violence and discrimination. Evaluation of this project has documented excellent results (Document review). For example, the project built youth-friendly corners where around 178,346 adolescents and young people were able to access ASRH information and services; 1,001,505 adolescents and youth were reached through awareness-raising activities to increase referrals to health centres for youth-friendly services; 12,756 out-of-school adolescents and youth were equipped with knowledge and skills on how to make life decisions; and 120,334 in-school adolescents and youth received reliable, integrated health promotion messages through school health clubs (Document reviews). With life skills support, first-time young mothers were economically empowered to live a life with dignity. Over a million adolescents and youth were reached through awareness-raising activities to increase adolescent and youth referrals to health centres for youth-friendly services (Document reviews, Site Visits, IDI, KII).

Further desk reviews show that the 8th CP interventions supported the establishment of health clubs at schools in districts and refugee camps. As a result, 120,334 in school adolescents and youth received reliable integrated health promotion messages to increase awareness on SRH and gender-based violence services through health clubs in target districts and refugee camps. Young people were also supported by UNFPA to generate innovative solutions for sexual and reproductive health issues. Four innovative solutions were selected from 501 applicants and awarded through the iAccelerator Phase 5. The iAccelerator is an initiative that provides a platform for youth to address ASRH, disability

inclusion and young people's mental health using innovative ideas. The capacity of peer educators was also strengthened and equipped with the life skills and sexual and reproductive health mentorship to enhance the quality of service provision.

UNFPA supported 21 youth-led organizations under the umbrella of AfriYAN through capacity building of the network members. This programme enhanced youth capacity to advocate for adolescent SRHR and the removal of barriers that hinder young people's access to ASRH information and services. Youth participation and engagement have resulted in support from the Prime Minister's office to revise the Reproductive Law to remove the age of consent for young people to access ASRH information and services (Document review, KII, IDI).

Youth-driven solutions to adolescent pregnancy

UNFPA invests in youth-led innovation through targeted support to youth-led organizations and initiatives to pilot new models for a healthy future. Implemented by Imbuto Foundation, in partnership with UNFPA, the Ministry of Youth and Culture and KOICA, the innovation iAccelerator Phase 2 sought to generate innovative, youth-led solutions to increase utilization of health services and healthy attitudes and behaviours among young people. The challenge addressed by iAccelerator applicants was "Availing adolescent sexual reproductive health information and services as a way of preventing adolescent pregnancies**".** The three best solutions were awarded $10,000 each as seed capital for their businesses and will receive three months of mentorship and training. Details of the mentorship, training and outcome of this investment has not been evaluated.

The programme strengthened the capacity of 81 youth leaders from the National Youth Council in adolescent sexual and reproductive health advocacy and youth development. This led to the development of advocacy action plans to be implemented by youth leaders in three districts of the programme's operations. For more tailored capacity building interventions, a capacity needs assessment of youth-led organizations was conducted to guide the development of a capacity building plan. During the field work, it was not clear whether the youth leaders implemented the advocacy action plans.

More than 150 community leaders, parents and youth were engaged in intergenerational dialogues in four districts in line with the 'intergenerational solidarity' theme of the 2022 International Youth Day. Parents and opinion leaders committed to improve communication with young people and vice-versa to eradicate risky behaviours such as substance abuse leading to mental health issues. Moreover, meetings with young people were held and participants trained on adolescent SRHR as well as climate change (Document reviews)

Progress on the implementation of the ICPD25 Rwanda Commitment was reviewed during a high-level national stock-taking workshop organized in collaboration with the Ministry of Health and AfriYAN. The meeting resolved to accelerate the removal of social and legal barriers to young people's empowerment and access to SRH services. The programme completed a situational analysis of the Menstrual Health issues to inform the development of an intervention strategy in menstrual health. The programme engaged 50 young people on menstrual health issues for Menstrual Health Day. The insights generated contributed to the development of a policy brief to support advocacy efforts. Coordination meetings of the joint Safeguarding Youth Programme took place to highlight progress and a specific coordination mechanism was designed in consultation with SDC (Document review, IDI).

The CO, in partnership with the ministries of Health, Education, Youth and Gender, led a study of adolescent pregnancy to document the scale and impact of the 'Neglected crisis of unintended pregnancy". Findings have not yet been disseminated however it is expected that the report will reveal the scale, causes and impact of unintended pregnancy and offer solutions on how to address this.

Through various awareness raising activities, the 8th CP interventions on adolescents and youth reached 426,000 adolescents and youth out of the annual target of 500,000. Interventions increased referrals to health centres for youth-friendly services, increased school re-enrolment, reduced gender-based violence incidents and improved interpersonal relations between parents and their children. Adolescents and youth made a choice to seek youth-friendly services and were referred to youth corners by peer educators. The 8th CP strengthened the capacity of 892 teachers from four districts (Bugesera and Kayonza, Burera and Musanze) on the delivery of CSE in school and provided reference materials. A total of 81 additional Master Trainers benefitted from a 10-day training and are now supporting teacher training activities. A total of 221 peer educators (50:50 ratio female to male) have been trained and deployed and they comprise the three-district peer educator network. The peer educators played a vital role in creating community awareness and mobilizing young people for services. UNFPA also engaged 20 religious and community leaders to support interventions challenging harmful cultural norms on gender equality and CSE through forums and policy dialogues. Monthly meetings with religious and leaders were held to reflect on their roles in promoting gender equality and how to support youth within their churches. (Document reviews, IDI).

A total of 186 health care providers increased their capacities in youth-friendly health service provision. In addition, 27 health facilities were provided with basic equipment to improve the quality of service provision. Through a mixed approach combining social marketing and free distribution, a total of 2,636,870 condoms were distributed to young people under 25 years old. In addition, the themes of SRH and STIs (including HIV and AIDS) were widely discussed, especially in refugee camps, even informally between friends and neighbours and myths around SRH were unveiled and demystified, following the promotion of knowledge and skills in SRH under UNFPA support. The openness and confidence young people now show when discussing SRH, which used to be a taboo in Rwandan culture, is also viewed as a positive outcome of the programme.

Despite visible achievements, there is still a long way to go, considering the population that is still to be reached. Interviewees and beneficiaries pointed out that people in deep rural areas have not received this information and that having one youth centre at sector level is not enough, centres should be opened at cell level. They showed that even in Kigali city the adolescent SRHR intervention should be made permanent to ensure all children will have access as they reach adolescence.

Another concern raised was the working conditions of the peer educators in the community and refugee camps. Peer educators lack basic equipment needed to carry out their work such as umbrellas and waterproof jackets, materials for ASRH awareness (e.g. sex education materials and condoms etc), and the skills to support adolescent mothers who attend training sessions while they are with their babies. Activities such as educational games are also needed at youth corners and youth centres. Focus group participants suggested that a youth forum should be created at village level to increase opportunities for awareness-raising outside of the centres and reach more young people. Religious leaders sought the inclusion of parents in the promotion of SRHR awareness and skills.

In the refugee camp, adolescent mothers have shown benefits from services at youth corners. Interventions such as intergenerational dialogues and advice have helped them to feel integrated and supported, to know how to prevent unintended pregnancies and make informed decisions. This shows

that UNFPA's focus on providing information about SRHR has equipped adolescents and youth to control their sexual and reproductive health and improve their wellbeing. The only negative is that much greater coverage is needed to reach more people in the community (Document reviews, KII, IDI).

Further document reviews and stakeholder interviews revealed UNFPA supported the Rwanda Biomedical Centre to implement an ASRH mentorship programme for health-care providers in health centres, including community health workers in the catchment area. The activity aimed to equip the health-care providers with enhanced knowledge and skills on how to deliver youth-friendly services in health facilities and was implemented in three UNFPA-supported districts of the Western province. All 63 beneficiary health facilities received ASRH IEC materials including 2000 booklets on how parents can communicate with their children on ASRH subjects, and 30 health facilities received ASRH manuals and computers to use in youth corners. This was followed by orientation of 231 community health workers on ASRH to enable them to better support young people with basic ASRH information and referrals to health facilities.

In terms of contribution analysis, the various interventions for adolescents and youth components were intended to improve overall adolescent and youth sexual and reproductive health; increase family planning use and reduce unmet need for family planning, thereby preventing adolescent pregnancies known to contribute to maternal death. Although there is a recorded marginal increase in use of family planning and ASRH services, there is still an overall increase in adolescent pregnancy in the country. It is expected that increased investment in and implementation of innovative interventions will lead to improvements in youth health, and reductions in adolescent pregnancy and unmet need for family planning.

4.2.2 Enhancing generation and use of disaggregated data to inform policies and programmes

Output 4 states that "Government institutions at national and subnational levels are better able to generate and use disaggregated data to inform policies and programmes that address inequalities in development and humanitarian settings. UNFPA will use its comparative advantage to support data collection and analysis to identify the most vulnerable populations and prioritize these in advocacy interventions". The output was planned to be implemented by the following strategic interventions:

- Providing technical assistance and mobilization of resources to conduct the 2022 Population and Housing Census and the Demographic and Health Survey 2019/2020.
- Supporting the National Institute of Statistics to improve national data collection systems and technologies to allow for the collection of age, sex and disability disaggregated data at all geographical levels to inform gender-sensitive policymaking.
- Conducting policy dialogue and advocacy to enhance access to and use available data for programme monitoring and evaluation; and
- Advocating and providing technical support for the integration of the Demographic Dividend study recommendations in national development frameworks, including in sectoral and district development strategies.

Accurate data through the census is important to inform policies and the socioeconomic development agenda in achieving the SDGs. The One UN Joint Programme, with UNFPA as the lead agency on population and data, supported the Government of Rwanda to conduct the first digital Population and Housing Census, a massive and complex exercise to ensure that everyone is counted.

Through the United Nations Joint Programme on Data, with UNFPA as the lead, secured $2 million to support all census related activities. The data collected through the census highlighted gaps in achieving NST1 and informed the design of NST2. Rwanda used digital technologies for the first time (computer-assisted personnel interviewing and mobile technologies for data collection and analysis) based on the United Nations guidelines for the 2020 rounds of census. These technologies helped immensely in keeping census planned activities on track despite COVID-19 epidemic movement restrictions, and in obtaining real-time information during data collection which resulted in a population coverage beyond 98 per cent during 16–30 August 2022.

The fifth Population and Housing Census conducted in 2022. Both exercises have been completed and detailed reports were published on the following themes: educational characteristics of the population, socioeconomic status of youth, data quality assessment, socio economic status of people with disabilities, socio-economic status of children, economic activity, population projection, social-cultural characteristics, socioeconomic status of elderly people, non-monetary poverty, agriculture, migration and spatial mobility, mortality, fertility, marital status and nuptiality, housing and households characteristics, population size, structure and distribution, etc. (Document reviews). It is expected that these reports are now being used by policymakers, researchers and students to inform programme decisions (Document reviews and KII). However, there is no evidence of dissemination of census reports and promotion of how to use the data for planning and programming. UNFPA provided technical assistance for the relevant data activities. It also provided support for the procurement of the required ICT tools such as ARC-GIS software, computers and tablets, and the training of enumerators for the census exercise.

According to document reviews and stakeholder interviews, the generation and utilization of disaggregated data for participatory and evidence-based policy formulation and planning at all levels has been implemented. The 8th CP has contributed to enhancing generation and use of disaggregated data to inform policies and programmes through the support for the generation of data. UNFPA, through the One UN Joint Programme on Data, recruited 12 international experts, predominantly from African countries, to formulate 18 thematic papers/monographs to use census data to inform policies and planning decisions (KII). The CO also supported the implementation of the RDHS 2019/2020. UNFPA mobilized partners to support the RDHS 2019/2020 and supported the development of the National Strategy for the Development of Statistics which coordinates support to strengthen organizational capacity for data production.

The Rwanda Demographic Dividend profile was launched and integrated into the seven-year National Strategy for Transformation and sector strategic plans. The profile was widely disseminated to all relevant sectors, Parliament, Prime Minister's Office and the Ministry of Economy and Finance. With support from UNFPA, a civil registration and vital statistics web-based application is now functional and used by civil registration officers and health centre data management to register vital events and report on population data in targeted districts. The domestication of SDGs was supported through on-going data collection such as household living conditions survey.

In a bid to better generate and use disaggregated data to inform policies and programmes that address inequalities in development and humanitarian settings, UNFPA CO successfully coordinated United Nations agencies to submit their requests for additional indicators to be collected through the RDHS and advocated for their integration into the RDHS6. Technical and financial support was provided (Document review and interviews).

Document review and interviews revealed that UNFPA hired a consultant to support the National Institute for Statistics in Rwanda (NISR) to finalise the Sixth Integrated Household Living Conditions Survey (EICV6) report analysis and capacity development of its staff. The civil registration and vital statistics web-based system was substantially strengthened to include births, deaths, marriages, divorces and adoptions. Linking administration, health facilities and community-based insurance in the system has played a key role in ensuring that no one is left behind. Table 12 shows that all the output indicators in the Resources and Results Framework have been achieved. A key informant declared, "*We have done a lot for evidence generation and dissemination. We started with the Demographic Dividend study that was produced and integrated the recommendations in the National Strategy for Transformation on how to harness the demographic dividend… We supported the NISR to conduct the first-ever digital census… and right now we are developing the thematic reports. There is also household living conditions survey."* Another informant said, "*Right now we are doing the evaluation of the ICPD Programme of Action evaluating the declarations on Population and Development*."

4.2.3 Integrated cross-cutting issues related to human rights, gender perspectives and disability inclusion in the country programme

The 8th CP was designed in alignment with the UNFPA global SP 2018–2021, which aimed at achieving universal access to SRHR through a deliberate focus on women, adolescents and youth with gender, human rights and population dynamics as key enablers and accelerators. From the outset, the CO prioritized a gender-transformative approach to tackle deeply entrenched social norms that fuel gender imbalances and human rights violations such as gender-based violence. Hence, the CO's focus on adolescents and youth as a key pillar and the promotion of CSE in shaping positive gender relations. The primary intention of integrating CSE in national school curricula was to instil positive values, attitudes, and behaviours from an early age thereby, enabling children to make a healthy transition from childhood to adulthood, to develop equal gender relations, bodily autonomy and to make informed decisions about sexuality and relationships, resulting in greater health and education outcomes.

During the cycle, a national baseline survey on CSE was undertaken to measure change in attitudes, practices and behaviours over time. Moreover, a Gender Marker to measure investment in gender and women's empowerment was introduced and staff were trained on its use, including UNFPA upstream work which contributed to the Ministry of Health adoption and implementation of the Family Planning and Adolescent Sexual and Reproductive Health Strategic Plan (2018–2024). Further, gender dimensions, human rights and gender-based violence were equally integrated in the CO refugee response in the 6 refugee camps and are covered in emergency response training.

Human rights, gender equality, and inclusion principles were respected in the implementation of the 8th CP. Their consideration started right from the planning phase up to the evaluation time. These principles are provided in all international and national reference documents such as SDGs[82], NST1, UNDAP, as well as policy and strategic documents, which have inspired the design of the 8th CP and remain relevant during the implementation by IPs. For the adolescents and youth component, girls and boys are equal beneficiaries and actors. They can access to and use the youth corners and youth centres equally, are recruited among the peer educators, receive advice, or are referred to health centre without discrimination based on gender (Document review, KII and IDI). Persons with disabilities were invited to participate in all programme activities and encouraged to use SRHR services at the

[82] United Nations. Sustainable Development Goals.

youth corners and youth health centres. Youth corners are being built to ensure their accessibility to all, including those with disabilities, for example by avoiding stairs. Gender equality is a key priority, but the CO did not look at the cause of gender inequality. There was no attempt to address negative cultural norms.

Respect for human rights manifests in various ways, for example through intergenerational dialogue, a process used by IPs to facilitate conversations between adolescent mothers and their parents. Due of early pregnancy, some young mothers are rejected or oppressed by their families. The intergenerational dialogues take time to create a space where parents and children can speak and negotiate reintegration of daughters into the family. Through this process, many adolescent mothers were reintegrated into their families and returned to school. One adolescent mother testified, "*I have changed as well. I left groups of people that would deceive me, I am in good terms with my parents in everything because my behaviour has changed positively. There are three other adolescent mothers who had left their parents but now came back and were received and they live peacefully together*." (FGD, IDI and Document review).

The 8th CP also emphasised the principle of "Leaving no one behind" in its activities. UNFPA supported the integration of key population-friendly services including female sex workers in the public health system. In 19 health facilities, including four from Nyamasheke and Rusizi, 19 out of 35 health service providers have been trained to help female sex workers to access SRH and HIV services. In further evidence of promoting "leave no one behind", UNFPA and partners included first-time young mothers in SRHR services. Adolescent pregnancy and early motherhood take an enormous toll on girls' education, discrimination, stigmatization, and low-income earning potential which can lead to continuous poverty. Most girls who become pregnant are forced to drop out of school and are more likely to become pregnant again when not given the right information and services (Document reviews, FGD). Through the First-Time Young Mothers Programme, implemented with Imbuto Foundation, many adolescent mothers from Rubavu and Rusizi districts were able to access socioeconomic support (Document reviews).

Respect for human rights is also seen in the privacy and freedom afforded to young people in the youth-friendly facilities. When adolescents and youth visit these facilities they report feeling confident, secured, free, and independent (IDI, Observation). In each of the youth corners, there are separate rooms for different activities and consultations. Economic support is also perceived as respect for human rights. An adolescent mother supported by Good Neighbors International mentioned that while people who used to mock her because of pregnancy, now (after being supported by the project) she has the courage to reply, *"say whatever you want to say, what I know is that now I am someone, I am a human, I am not an outcast. None can look down on me again. How can you look down on me while I am independent and contribute to your lives? You need me to survive, I buy a soap that everybody can use at home. But before I had that capacity you could not allow me to use your own. Good Neighbors International has really helped us very much, no basis on which we can blame them." (FGD, IDI)*

Document review, key informant and in-depth interviews revealed that there are many results emanating from these activities. The utilization of modern contraceptive methods has risen from 48 per cent to 58 per cent (Document review). UNFPA's support extended to the provision of equipment and commodities, the development of evidence-based policies and guidelines, the expansion of interventions in 18 second-generation health posts to facilitate service access, and the reinforcement of maternal, perinatal, and child mortality surveillance and response. These contributions led to a

decline in the maternal mortality ratio, dropping to 203 in 2019–2020 from 210 per 100,000 live births in 2014–2015. Facility-based deliveries also increased from 91 per cent in 2014–2015 to 93 per cent in 2019–2020, while skilled assistance rose from 91 per cent to 94 per cent. The utilization of modern contraceptives in humanitarian settings in Rwanda has shown an increase, rising from 30.1 per cent in 2018 to 34.96 per cent as of October 2022. This growth can be attributed to extensive community mobilization efforts and outreach sessions (Document reviews, KII and IDI). Clearly addressing gender equality and human right issues is bound to contribute to achieving zero maternal mortality and zero gender-based violence.

A total of 339,447 students have had their awareness raised on ASRH raised. This has led to a reduction in adolescent pregnancies, declining from 7.3 per cent in 2015 to 6.1 per cent in 2022. The utilization of modern contraceptives in humanitarian settings in Rwanda has experienced a slight uptick, moving from 30.1 per cent in 2018 to 34.96 per cent by October 2022. A total of 1,113 service providers underwent training in various aspects of ASRH, leading to a notable enhancement in the quality of health-care services provided. A concrete illustration of this improvement can be seen in Mahama, where the implementation of the Kuja Kuja system resulted in customer satisfaction ratings surging from 46.3 per cent in 2018 to over 80 per cent as of November 2022 (Document review, KII and IDI). Thus, UNFPA initiatives have resulted in increased awareness, demand, and utilization of available ASRH services. As a result, there has been a reduction in adolescent pregnancies, dropping from 7.5 per cent in 2014–2015 to 5.5 per cent in 2019–2020 (IDI, KII and Document reviews).

Table 12: Summary of 8th UNFPA/Rwanda Country Programme performance 2018–2024

Output indicators	**Baseline/2018**	**Results 2023**	**Target/2024**	**Achieved**
Outcome 1: Sexual and reproductive health				
Outcome indicators				
Contraceptive prevalence rate	47.5	57	57	Achieved
Adolescent pregnancy rate 15–19	7.3	6	6	Achieved
Output 1: National and sub-national institutions have enhanced capacities to develop and implement strategies, guidelines and standards for increased access to information and services on sexual and reproductive health and reproductive rights				
National and district-level financial sustainability plans for family planning services available	No	Yes	Yes	Achieved
Updated and revised guidelines on adolescent sexual and reproductive health, family planning, maternal, neonatal and child health, HIV/STIs and gender-based violence available and disseminated	No	Yes	Yes	Achieved
Number of midwifery schools using a standardized competency-based academic curriculum	4	7	1	Not achieved
Output 2: National and subnational institutions have enhanced capacities to effectively deliver integrated, youth-friendly SRH services, including for key populations and in humanitarian situations				
Proportion of service delivery points without stock-outs	93	96	100	Achieved
Percentage of health centres in the target districts that provide youth-friendly services as per national standards	29.5	50	18	Not Achieved

Output indicators	Baseline/2018	Results 2023	Target/2024	Achieved
Percentage of female sex workers accessing sexual and reproductive health and HIV services in target districts: Rusizi Nyamasheke Karongi	 50 50 79	 70 70 95	NA	No data
Number of refugee camps with adolescent SRH services	2	5	5	Achieved
Outcome 2: Adolescent and youth development				
Outcome indicator				
Number of youth-led organisations that participate in the formulation of national sexual and reproductive health policies	1	21	10	Exceeded
Output 1: Young people especially young girls are equipped with knowledge and skills to make informed decisions on reproductive health and reproductive rights and to fully participate in development and humanitarian actions				
Number of youth-led organisations and networks with capacity to participate in national sexual and reproductive health-related policy dialogue, advocacy and programming including in humanitarian settings	1	21	10	Exceeded
Number of partnerships established for piloting and transition-to-scale of innovations in adolescent sexual and reproductive health	0	10	2	Exceeded
Percentage of public and private schools implementing CSE according to the national education curricula	0	100	30	Exceeded
Outcome 4: Population dynamics				
Outcome indicators				
Census data collected, processed and analysed	No	Yes	Yes	Achieved
Proportion of SDG indicators produced in accordance with the Fundamental Principles of Official Statistics (out of a total of 232 SDG indicators)	23	70	70	Achieved
Output indicators				
2019 RDHS report available and disseminated as per dissemination plan	No	Yes	Yes	Achieved
Number of UNFPA priority SDG indicators integrated into population-based surveys and national data collection systems	12	14	14	Achieved
Number of national development frameworks that have integrated the demographic dividend study recommendations	0	4	4	Achieved
2022 Population and Housing census project document available	0	Yes	Yes	Achieved

The Parliament convened a high-level partners' advocacy meeting, through Rwanda Parliamentary Network on Population and Development (RPRPD) and UNFPA, to review progress, assess gaps, and recommit to the Cairo Declaration with focus on family planning in Rwanda. Several resolutions were derived from the discussions including to revise existing laws and policies to facilitate young people's access on SRH services; increase domestic budgetary allocation to family planning programs and activities; encourage faith-based organizations to raise awareness and promote family planning to their followers; and to collaborate with all partners in family planning to establish complementary programs.

For the integration of HIV/AIDS and adolescent sexual and reproductive health, UNFPA works closely with government, United Nations agencies and other partners to ensure that reproductive health is integrated into emergency responses, with a particular focus on youth. UNFPA supported the International Conference on AIDS and Sexually Transmitted Infections in Africa organized by the Society for AIDS in Africa, in close collaboration with the Government of Rwanda, The conference aimed at promoting community, scientific, and technological innovations for ending AIDS.

Through the financial support provided by the Government of Japan, desk reviews and interviews show that tremendous achievements have been registered including reduced incidences of maternal death by strengthening the referral system; 1,388 safe births; and 69,734 adults and young people reached with SRH information including HIV, family planning and gender-based violence prevention and management. In support to One UN humanitarian interventions in Rwanda, UNFPA has implemented SRH services in Mahama refugee camp, including family planning and HIV/AIDS counselling and testing, as well as screening and management services for STIs. In addition to supporting tailored interventions for young people, UNFPA has initiated three permanent youth-friendly centres managed by a full-time midwife in charge of adolescent sexual and reproductive health. Since their establishment, more than 4,311 adolescents and young people have used the SRH clinical services. Furthermore, 636,724 male condoms and 78 female condoms were distributed to young people for prevention of HIV/AIDS and unwanted pregnancies (Document reviews). Another 611 boys and 782 girls were tested for HIV and 58 boys, and 167 girls were screened and treated for STIs. A total 431 of adolescent girls used modern contraceptive methods. As community health workers distribute condoms throughout the camp (i.e. in toilets and the youth-friendly spaces), adolescents can access them anonymously and free of charge (Document reviews).

Generally, Table 12 shows that for Outcome 1, two of the outcome indicators are achieved while only two output indicators are achieved. For Output 1, only two indicators are achieved. One outcome indicator of Outcome 1 and outputs of adolescents and youth component are achieved. Adolescents and Youth component has strengthened the focus on young people. Both the KOICA and Safeguarding Youth Programme projects have demonstrated good results and are considered as good examples of best practice. For population dynamics, one outcome indicator and three output indicators are achieved.

Factors responsible for the effectiveness of the 8th CP

There are several factors that facilitated the achievement of the outcomes and outputs at such a high level. One primary factor has to do with joint team delivery at CO with implementation partners and district programme coordinators. A KII noted that, "the district programme coordinators made our work very easy. They are knowledgeable and active in the district level interventions." Another facilitating factor is the mobilization of non-core resources through development partners and the Strategic Investment Facility. There is also a strong partnership between UNFPA CO and

implementing partners. More important is the political will and high-level support both from the Government of Rwanda and UNFPA Regional and HQ offices promoting the delivery of various international commitments. The fact that the 8th CP is focused on very key priority areas of the Government's development strategies is also an added impetus for the achievement.

Document review indicates that UNFPA CO, through the 8th CP, has produced and disseminated several knowledge products and methodologies whose relevance to the goals are significant. Some examples are the Family Planning Business Case dissemination, female sex workers estimation methodology, Demographic Dividend study, Family Planning Barriers study, and Condom Situation Analysis. Technology application in information and communication and social media has ensured business continuity. The CO involvement in major international events has also enhanced UNFPA visibility, distribution of upstream instruments, knowledge products and advocacy[83].

4.3 Efficiency

Evaluation Question 3: To what extent has UNFPA made good use of its human, time, financial and technical resources to pursue the achievement of the outcomes defined in the county programme? Were the programme activities and outputs produced in a cost- and time- efficient and quality manner?

Summary: The CO was generally efficient in mobilizing and managing resources for the four years of the 8th CP. Implementation rate ranged from 81 per cent to 98 per cent. There was efficiency in disbursing programme budgets to support the implementation of annual work plans, though some hiccups were noted. The UNFPA model implemented through government partnership, IPs and integration of some activities was efficient in IP annual work plans. The IPs and CO made good use of resources to implement approved component interventions. Based on the review of financial documents, stakeholder interviews, reviews of annual work plans and progress reports, all the outcome areas with specific outputs have made good use of the resources. Both national and international consultants with requisite skills were used in the implementation. Stakeholders were supportive of the approach UNFPA CO took to manage its staff, funds and technical resources. The UNFPA administrative and financial systems for the 8th CP were largely adequate and functional. UNFPA CO has a clear and robust system for ensuring checks and balances and ensuring that IPs were accountable for deliverables in a timely manner. The evaluation team established that the UNFPA resource management systems were followed to the book and were efficient to support timely implementation of project activities and hence no qualified audit is reported. Programme activities and outputs were produced in a cost- and time-efficient and quality manner.

Details

Human resources

The 8th CP is managed largely through National Execution modalities and some interventions are also implemented via direct execution. Led by the Deputy Country Representative, outcome leads oversee quality of programming and programme implementation, resource mobilization and provision of technical support in their respective thematic areas. At the CO, "*we have CP governance structures: senior management, programme review meeting, and other project-based arrangements*". (KII).

There were sufficient qualified staff at the CO who contributed to the design of the country

[83] Mid-term review of the UNFPA 8th Country Programme.

programme using the new upstream programming approach. There were 34 staff members in the CO. As of the midway point, there was no need to recruit additional core staff members. In 2021, instead of the initial 34 core staff members, there were 32. Additional personnel were sourced from non-core resources. The filling of the Deputy Representative position was done to enhance the capacity to manage upstream programming effectively. The CO categorized staff according to resource types. There were six staff members under institutional resources, four under cost-shared resources: 19 under regular resources and nine under other resources[84]. In terms of the operations in the CO, a key informant noted: "we *have a senior management team made up of the Representative, Deputy Representative, Assistant Representative and Operations Manager, operating as the senior management team. Each of the Outcome Leads has a team of staff. The Deputy Representative is also the head of programmes. The senior management holds a weekly meeting to look into the overall management of the CO and also make relevant decisions*." (KII). The management team is regarded as the living body of the entire programme.

Based on stakeholder feedback in the latter half of the 8th CP, UNFPA could explore providing more capacity-building support to partners, particularly in areas like e-health and IT, and conducting rigorous modelling and coordinating high-level research in population dynamics and big data. Providing online and upskilling training to staff in domains related to their normative work, especially in taking up their upstream responsibilities, was suggested as a valuable initiative. Strengthening the communication team by providing more suitable equipment to enhance the effective dissemination of information was recommended. In summary, the shift to upstream programming affected human resources in various ways, including changes in staffing numbers and a focus on capacity building to meet the evolving demands of UNFPA's work (Document review). UNFPA provided support to partners who played a visible role in implementing the 8th CP, which was crucial for ensuring the successful implementation of the programme through partnerships. Capacity-building initiatives were also supported for partners, including training in laws and human rights instruments, protocols, the utilization of applications and databases, and the promotion of IT-based innovations.

However, it should be noted that during the 8th CP, there was recognition that the CO needed to continue enhancing the capacity of its human resources to effectively implement the 8th CP, especially in the context of upstream programming, for the remaining duration of the programme. One noticeable aspect of human resources at the CO is the lack of continuity in the tenure of staff, especially at the management level. The Country Representative that designed the 8th CP left midway through and the new Representative came on board to complete the implementation. A new Deputy Representative recently joined the team while the Assistant Representative resigned. Many other staff have left. The M&E specialist is on contract. And despite having a population dynamics component to the 8th CP, there was no qualified population expert to oversee the strategic interventions. The transition to upstream programming was expected to have an impact on human resources in the CO. One factor that affects the implementation of the programme is the delay in staff recruitment. Commenting on the quality and competence of the staff, a key informant observed *"... because we have the staff that are required to do the work, we have some delays in staff recruitment which sometimes puts a burden on the existing staff to implement and ensure the programme is kept on track. It takes an average of more than six months to fill a vacant position*." [KII). When this delay occurs "*we have to use temporary positions like consultants or United Nations volunteers*." (KII).

Financial resources

[84] Data from UNFPA Rwanda Country Office Staff Profile, April 2023.

The UNFPA administrative and financial systems for the CP were largely adequate and functional. UNFPA has a clear and robust system for ensuring checks and balances, and to ensure that IPs were accountable for deliverables in a timely manner. The CO team reviewed IP quarterly work plans, partner financial and programme reports and provided required feedback mainly on completeness, quality of reporting and absorption/utilization rates of the funds. UNFPA CO also ensured that regular audits of UNFPA accounts were carried out.

According to the CP quarterly and annual reports, efficiency was well monitored, and the results of the evaluation have shown good performance. There was 97 per cent implementation rate for regular resources, 95 per cent implementation for non-core resources, and 90 per cent of total annual work-plan output indicators. Despite the COVID context and all the adjustments that it has imposed (for example, the closure of two refugee camps), UNFPA was able to achieve 98 per cent of fund utilization for regular resources and 94 per cent for non-core resources. The annual work plan was achieved at 87 per cent by September 2022. The assessment of financial management conducted among the implementing partners found low risk, which indicates good management of both UNFPA and its IPs. In 2023, all administrative and management activities—human resources, administrative processes like recruitment, induction, leave, procurement plan and budget—were completed within the internal corporate deadline. ICT supported corporate delivery at 99 per cent and procurement plan implemented at 95 per cent (Document reviews).

Further desk reviews and interviews with IPs revealed that there was efficiency in the disbursement of budgets to support programme implementation by IPs and direct execution modality. Table 10 shows an increase of 81 per cent to 98 per cent implementation rate for the years 2018–2023. Some IPs complained of delays in fund release but noted that the delay did not affect their capacity to implement planned activities. The CO reported that the delays in fund release were partly caused by IPs non-conformity with UNFPA financial and reporting procedures (Document reviews, IDI).

UNFPA Rwanda programme activities are executed primarily through IPs such as government agencies (REB, RMC, NISR) and non-government agencies (ALIGHT, AHA, SFH, Swiss School of Tropical Public Health, to name a few). Each of these IPs was engaged after due micro-assessment which established their organization mandate, technical expertise, action plans, capacity and outreach. These IPs have consistently been engaged in CO programme implementation since 2013. The partnership with these entities facilitated efficiency in budgets, accessing wider areas, and outreach to hard-to reach areas and locations like refugee camps. The flipside of this partnership is the need to build capacity of IPs in technical and management aspects hence incurring time and costs of monitoring and validating IPs project activities and data (Document review). Another is the need to capacitate IPs led by nationals so that the benefits of interventions can be sustained.

Programme management

In the 8th CP, each implementing partner prepared a work plan to facilitate programme implementation. The work plan is discussed by all relevant parties based on agreed guidelines and submitted to UNFPA for approval on an annual basis. A standard digitalized Fund Authorization and Certificate of Expenditures (E-FACE) Form, reflecting the activity lines of the work plan, is used by implementing partners to request an advance of funds or to secure the agreement that UNFPA will reimburse or directly pay for planned expenditures. The E-FACE is also used to report on the full utilization of all funds received and submitted to UNFPA within three months after receipt of the funds.

There are two ways to spend funds. One is the National Execution which is applicable to IPs, ministries, institutions and NGOs. It entails transfer of funds to IPs through annual work plan and IP execution of the planned activities and disbursement of funds against progress and financial reports. The Direct Execution is used when there is lack of national capacity to implement and the function is directly implemented by UNFPA, for example when external consultants are needed for specific technical assistance. Some aspects of the 8th CP were integrated in government ministries, especially activities bordering on advocacy and dialogue. This integration had a positive impact on efficient, effective use of resources and synergies. At the time of the evaluation, all the programme targets were already achieved. Desk reviews, KII and IDI confirmed that financial resources allocated through annual work plans were sufficient for the various planned results, although they did not fail to ask for increased funding (Table 11).

UNFPA CO adopted the HACT model of payment which can be any of these types: 1) direct payment, 2) direct cash transfer and 3) reimbursement and 4) agency. Depending on the risk level of the implementing partner, any of the HACT model of payment can be used the cash transfer process involves: (i) Direct Cash Transfer (DCT) directly provided to the IP in the form of quarterly advances prior to the start of activities, and (ii) direct payment system where funds are paid directly to participants when IPs are conducting activities. If liquidation of funds is done well, the implementing partners stand a better chance of being refunded. Currently, all activities are reflected in GPS which allows for transparency and accountability.

Regular follow-up was made with IPs for financial tracking. Fund disbursements are made based on standard quarterly reporting. There was perception among national stakeholders that UNFPA's processes are too complicated and burdensome in terms of monitoring activities. IPs expressed their difficulties with UNFPA's reporting and disbursement procedures because of the short quarterly period in which to implement and report. In some cases, this delayed their implementation activities. The implication of this is that funding may not be received for several weeks and when received the IP will be required to deliver three months' worth of activities in only two months. Despite reported challenges in preparing reports by IPs, there was a high implementation rate across all programme areas. Key informants and in-depth interviewees commended the UNFPA CO for having both internal and external audit systems and the use of the M&E tools that help to track progress but noted that the process is cumbersome. No IPs reported cancellation or postponement of programs because all activities were done according to the work plans. There is no qualified audit either at the level of the CO or the IPs.

The timing and availability of resources is crucial to the success of the programme implementation. From observations on project documents, project implementation site visits, and spot checks conducted during the evaluation exercise, there has been efficient use of resources but there is need for a corresponding increase in human resources to match and fully manage the projects in a more efficient manner. Some of the partners implementing the training and leadership programs, for their part, indicated that funds had been transferred on time and that the programme management, including fund transfers, had been efficient.

In terms of the quality of communication, partners felt that on some occasions communication with UNFPA could have been improved to better understand implementation strategies. Some implementing partners and beneficiaries felt that more inter-partner meetings at the inception stage would have enabled them to know each other better and acquire a deeper understanding of the project (IDI).

4.4 Sustainability

Evaluation question 4: To what extent has UNFPA been able to support implementing partners and rights-holders (notably, women, adolescents, and youth) in developing capacities and establishing mechanisms to ensure the durability of effects?

Summary: The CP has played a pivotal role in establishing crucial building blocks for the future sustainability of SRHR, adolescent and youth and population dynamics in Rwanda. Through capacity-building initiatives, knowledge transfer and institutional strengthening, the programme has empowered local stakeholders to effectively manage and continue the services independently. The integration of these services into existing health-care systems and policies created a solid foundation for their continued implementation. A sense of ownership of programme interventions and durability of goals was developed by the programming approach of joint planning, intensive consultation and assessment of the needs and priorities. Interventions that address long-term development issues which focused on immediate needs in the context of Rwanda are likely to be sustainable. Ownership of the SRHR, adolescent and youth and population dynamics initiatives and their results have been relatively high with capacities built both at organizational and staff levels. However, capacities are still varying across the different IPs and support is needed in the generation and analysis of data and to prepare for the census and survey undertakings. Most of the SRH, adolescent and youth and population dynamics interventions will remain sustainable. Likelihood of sustainability of effects is guaranteed in the outcome areas where the interventions have government and community buy-in. Only staff attrition, limited financial resources or lack of political support can limit the sustainability effect. Overall, UNFPA has been able to support IPs and right-holders by developing their capacities and contributing to the establishment of mechanisms for durable effects.

Detail

Sustainability assessment refers to the extent to which supported programme activities and goals are likely to continue without UNFPA's support; or the willingness and capacity of implementing partners to maintain provision of these services without further programme technical and financial support from UNFPA. The evaluation team assessed the extent to which the supported 8th CP interventions are likely to continue without UNFPA's financial and technical support. Consultation with stakeholders in prioritization workshops, needs assessment via 7th CP reports and surveys, and census reports and joint planning and programming with IPs certainly developed a sense of ownership of programme interventions and goals.

There are several key activities that give the impression that the programme components will be durable. The programme components are relevant to the national priorities and population needs in Rwanda, creating an environment of national ownership of the UNFPA 8th CP. The fact that UNFPA works in collaboration with key government ministries means that UNFPA support is strategically positioned in the long-term development of Government policy. The programme approach of participatory needs assessment, intensive consultations with stakeholders and joint programme planning with implementing partners helped develop a sense of ownership of programme interventions and goals during the 8th CP cycle.

Furthermore, this ownership and a direct implementation of UNFPA-supported interventions has built IP capacities and enhanced the likelihood of sustainability, provided IPs are able to maintain acquired results technically, institutionally and raise the necessary financial resources. Stakeholder interviews suggested that the CO should build the capacity of the IPs in fundraising so they could find additional

funding sources and reduce dependence on UNFPA. Commitment of UNFPA implementing partners in planning and implementing UNFPA-supported interventions, especially at the district levels, has effectively contributed to scaling up the capacity of those partners. However, as reported by many IPs, staff turnover and limited budgets are always a challenge for increased level of sustainability.

Sexual and reproductive health: UNFPA programme support in capacity building targeted at training of community health workers at the local level, such as health care providers and midwives, is likely to be sustainable as it focused on stakeholders who are more likely to be stable at the central and district levels and less subject to staff turnover. SRHR partners at both central and district levels noted that the training of the community health officers and the in-service training of the other midwifery cadres, development of relevant policies, guidelines and standards, and investment in building and equipping more health centres can be sustained if UNFPA support phases out. In fact, it was commonly acknowledged by all key informants and beneficiaries that investment on human resources for health is a masterstroke for sustainability of the 8th CP interventions (KII, IDI).

Adolescents and youth: It is possible that the management of the UNFPA-rehabilitated youth centres and disseminating educational messages on CSE could continue. Many of the youth centres have been in use at the time of the evaluation site visits, although the evaluation team did not witness any adolescents accessing services at the centres (due to privacy measures). The health clubs should be well managed to guarantee their continued usefulness. All adolescents and youth programme benefits will be sustained as there is an existing National Youth Policy.

Population dynamics: From the interviews and document reviews, it is clear that NISR can continue to use the resources and skills acquired in the implementation of the census and other surveys. The operationalisation of the National Development of Statistical System would be continued. In view of possible staff attrition, there is need for capacity training in data science and management. The 8th CP has built the capacities of implementing partners and rights-holders and contributed to the establishment of mechanisms for durable effects. The programme has enabled adolescents and youth and peer educators with knowledge and skills in SRHR, which will remain with them for life. In addition, these skills will be used to help the community as well. It was observed that peer educators have started making contributions in community meetings (during community work, family evening forum, village assembly), raising awareness about SRHR and thus becoming an advocate for the community.

The rights-holders' capacities are also built through vocational training, returning to school, and economic support for adolescent mothers. This was done in refugee camps and the community. Those who received this support are likely to become financially self-reliant, which gives hope of durability of wellbeing. Implementing partners have benefited also in capacity building. All IPs that participated in UNFPA 8th CP were trained in SRHR. Religious institutions were provided with tools to help link ASRH with the holy scriptures, thus facilitating their work of developing the holistic wellbeing of their congregation. In addition to these materials, religious leaders are now able to talk about sex with their members, something that was not freely done before. Most of them have also included SRHR in their strategic plans. Likewise, youth-led organizations have greater leadership and policy influence and have secured seats within national technical working groups and participated in elaborating national commitment for ICDP+25.[85]

[85] UNFPA (2019). Accelerating The Promise. The Report on the Nairobi Summit on ICPD25.

Existing mechanisms were strengthened also. Health systems were supported with infrastructure and equipment. Interventions by civil society organizations in the community were complemented by the existing plan in the districts. By using existing structures (youth councils, friends of family) this ensure that activities and achievements will be owned by the community who will continue to take care and develop them. Nevertheless, harmful social norms persist creating a stumbling block to the advancement of ASRHR awareness promotion. For example, survivors of rape feel they cannot report the perpetrator due to shame and stigma. One adolescent mother who participated in a FGD of peers explained how her sister-in-law, who is medical staff, prevented her from using family planning for fear that it would brand her as prostitute. Some parents also do not report the perpetrator when their daughter is sexually assaulted but rather try to deal with the matter in the family or marry the girl to the perpetrator to avoid shame and stigma (IDI).

4.5 Coordination

Evaluation question 5: To what extent has UNFPA contributed to the functioning and consolidation of the coordination mechanisms with other development stakeholders including the government, civil society, development partners, and UNCT for the development of Rwanda? To what extent has the UNFPA Rwanda Country Programme created synergies with other development programs and policies in Rwanda, to amplify results of the national agenda?

Summary: There is strong evidence of active and effective collaboration between the Government of Rwanda, UNCT and UNFPA Rwanda CO. UNFPA collaborates with specific national government ministries such as health, youth and gender to deliver on relevant aspects. The CO contributes to the functioning and consolidation of UNCT coordination mechanisms. Coordination mechanisms proved effective in joint planning and programming, complementary interventions and information sharing in coordination meetings, and advocacy. Coordination is also effective in joint advocacy. The UNFPA Rwanda CO participates actively in regular UNCT inter-agency sector working groups on health, gender, and data. UNFPA, working with United Nations agencies, built a synergy for implementation of many Joint Programmes such as the Joint Programme on Data and One UN SDG Fund. UNFPA takes leadership through the secretariat role in one of the Results Groups (RG3) on Data and Gender, and M&E task team. UNFPA has worked with other agencies to raise funds to build 1000 health posts and to conduct joint monitoring visits to intervention sites. South-South cooperation was ensured.

Details

Effective coordination mechanisms were established among stakeholders to achieve tangible results in the areas of SRHR, adolescents and youth, and population dynamics-related advocacy efforts. Regular inter-agency meetings, joint planning and information sharing played a pivotal role. The UNFPA CO in Rwanda has demonstrated a high degree of alignment with the wider development systems outlined in the UNDAP/UNSDCF 2018–2024. This has facilitated synergies and collaborative efforts to achieve common goals and address pressing issues within the country. UNFPA has contributed much to the functioning and consolidation of the coordination mechanisms with other development stakeholders in the country.

UNFPA Rwanda CP focus areas mirror the global mandates and policies of UNFPA, ensuring that the country specific interventions also contribute to the agency's global goals. The 8th CP has also been closely aligned with the priorities of the UNSDCF 2018–2024. UNFPA's focus on sexual and reproductive health, family planning and maternal health contribute to UNSDCF Outcome 3 which emphasizes improving health outcomes. Its support for population censuses and demographic surveys contributes to the UNSDCF Outcome 6 which emphasizes evidence-based policy making, while

UNFPA's programme on CSE and youth participation align with the UNSDCF Outcomes 1 and 3.

UNFPA contributed to the functioning and coordination of the UNCT in Rwanda in several ways. The CO actively participates in regular UNCT meetings, ensuring that issues related to reproductive health, gender equality and population dynamics are adequately represented in discussions and decisions. It provides technical expertise in its mandate areas such as reproductive health, gender-based violence, population data and youth empowerment.

UNFPA often collaborates with other United Nations agencies in joint programming initiatives on data, youth, gender, HIV, communication and One UN, ensuring that resources are used efficiently and interventions are synergistic. Joint Programmes contribute to achieving greater system-wide coherence that supports national development priorities. For example, the One UN collaborated with national partners to develop a programme dubbed "1000 health posts in the land of 1000 hills: promoting universal health coverage by catalysing investments in financially and environmentally sustainable primary health care," with the goal of reaching its vision for universal health coverage through increasing financial viability and sustainability (Document review).

UNFPA contributed to the functioning and consolidation of UNCT coordination mechanisms through various avenues: (i) Participation in regular meetings: UNFPA actively participates in regular UNCT meetings, ensuring that issues related to reproductive health, gender equality, and population dynamics are adequately represented in discussions and decisions. (ii) Technical expertise: UNFPA provides technical expertise in its mandate areas, such as reproductive health, gender-based violence, population data, and youth empowerment. This expertise is crucial for informed decision-making within the UNCT, (iii) Data sharing: UNFPA's work on population data is invaluable for the UNCT. Accurate demographic data informs development interventions. (iv) Capacity building: UNFPA often contributes to capacity-building efforts, training its partners in areas related to its mandate. (v) Advocacy: Within the UNCT, UNFPA advocates for issues related to its mandate, ensuring that reproductive health, gender equality, and related areas receive the attention they deserve in broader United Nations strategies and interventions.(vi) Emergency response: In humanitarian crises, UNFPA plays a crucial role by ensuring that reproductive health services are available in emergency settings and by addressing gender-based violence, which increases during crises. (vii) Resource mobilization: UNFPA Rwanda plays a role in mobilizing resources for joint United Nations initiatives, leveraging its global network and partnerships. (viii) Promotion of gender mainstreaming: UNFPA Rwanda ensures that gender considerations are mainstreamed across various United Nations initiatives, ensuring that programs are gender-sensitive and promote gender equality.

UNFPA plays a vital role in UNCT coordination mechanisms by providing technical expertise, data driven insights and sharing best practices. Its contributions extend beyond its core programme areas to foster cross-cutting collaboration and holistic development approaches.

4.6 Connectedness

Evaluation question 6: To what extent has UNFPA contributed to developing the capacity of local and national actors (government line ministries, youth and women's organizations, health facilities, communities, etc.) to better prepare for and respond to refugee situations?

Summary: UNFPA CO successfully took a continuum approach across the humanitarian and development nexus. The humanitarian activities have played a vital role in supporting the transitioning of affected populations towards longer-term developmental and resilience-related goals. The UNFPA provided support for developmental activities alongside its humanitarian interventions. UNFPA CO supported the deployment of health care workers across the districts of intervention to provide safe delivery services by skilled attendants, dignity kits and comprehensive emergency obstetric care. UNFPA CO also worked closely with the MoH to scale up midwifery education, increase capacity for delivery of emergency obstetric care and improve clinical practice for midwifery, nursing, and associate clinicians. Health centres and youth corners are accessible to refugees and host communities.

Details

The capacity of local and national actors to better prepare for and respond to the refugee situation was observed in the infrastructures established especially in the refugee camps, for example health centres and youth corners.

First-Time Mothers project extended to a refugee setting in 2020 with 165 beneficiaries reached with a comprehensive package including SRH information and services, gender-based violence prevention and response and livelihood activities in Mahama refugee camp. It was then scaled up in two other camps to equip three youth corners with IEC materials and other equipment in three refugee camps. ASRH services were initiated in Kigeme camp where 30 health service providers from Gihembe camp were trained to provide ASRH services (Document review)

The quality of health services in six refugee camps has been enhanced for the provision of SRH, HIV, family planning and gender-based violence services including those for adolescents and young people. A total of 27,281 adolescents and young people aged from 15 to 24 were reached by SRH and gender-based violence messages in humanitarian settings. UNFPA supported one Burundian and three Congolese refugee camps with 72 Emergency Reproductive Health Kits. 171 female sex workers from the three refugee camps were provided with a comprehensive package of services including HIV/STIs prevention awareness and condom distribution (Document review).

Increased understanding and social approval of family planning was achieved in three Congolese camps following three campaigns on the importance of using family planning methods and targeting 45 community leaders.

To support teacher training on SRH and gender-based violence, a manual and a simplified guide were developed and used to train 35 teachers from four schools in the host community of Gisagara and Nyamagabe districts. These schools are used by both refugee and host community students. UNFPA supported the rehabilitation of the maternity ward in Mugombwa refugee camp which has been completed and is currently operational providing SRH services in the camp (Document review, Observation).

Gender-based violence screening was initiated in health facilities in humanitarian settings where 1414 persons were screened for sexual and gender-based violence (431 in Nyabiheke, 240 in Gihembe and 743 in Mahama). Those who were eligible were linked to gender-based violence response services. (Document reviews, IDI). Through training sessions, the capacity of 24 health service providers and 175 COMMUNITY HEALTH WORKERs (including 20 peer educators and 109 female mentors) was

strengthened to deliver quality SRH, family planning and HIV/STIs services in Mugombwa, Kigeme and Kiziba **(**Document review, IDI).

Document reviews and stakeholder interviews confirmed UNFPA's humanitarians activities have played a vital role in supporting the transition of affected populations towards long-term development and resilience-related goals. In humanitarian settings (refugee camps) in Rwanda, UNFPA work typically involves both immediate humanitarian assistance and efforts to support longer-term development goals. UNFPA often works to ensure reproductive health services, including maternal and child health care, family planning and prevention of gender-based violence. UNFPA's support to health systems can have long-term impacts by improving the overall quality and accessibility of health care services which in turn contributes to the health and well-being of communities.

In a more developmental context, UNFPA's role extended beyond immediate service delivery to focus on capacity-building, policy advocacy and system strengthening. UNFPA acts as a catalyst for change, working with government, NGOs and other partners to ensure the sustained provision of essential services and the achievement of long-term development goals UNFPA's capacity-building initiatives for health-care providers and its support for the integration of reproductive health services into primary health care contribute to both immediate and long-term development outcomes (Document review and In-depth interview).

4.7 Cross-cutting issues

Gender equality and human rights

The UNFPA office has integrated human rights approaches into the programming and implementation of UNFPA's 8th CP interventions by prioritizing gender equality, informed decision-making and the elimination of discrimination. Activities have been designed to ensure accessibility, respect for individual autonomy and the protection of human rights across all programme components. Analysis of documents and key informant interviews shows that gender equality and human rights are integral parts of the UNFPA mandate and are essential for the achievement of the ICPD agenda on universal access to SRHR. Gender dimensions and human rights issues have been mainstreamed in family planning, HIV and humanitarian/refugee interventions in the six camps. Standalone interventions, such as the Healthy and Empowered project, have addressed the root causes of unequal gender relations through awareness-raising activities and campaigns focused on SRH, gender and gender-based violence. In refugee camps, capacity building of service providers on routine gender-based violence screening was a continuous intervention. Equally importantly, training for partners/actors in humanitarian and disaster response on the Minimum Initial Service Package (MISP) covers gender, gender-based violence and human rights principles. Additionally, the primary intention of integrating CSE into national school curricula was to instil positive values, attitudes, and behaviours to support a healthy transition from childhood to adulthood, equal gender relations, bodily autonomy and informed decisions about sexuality and relationships. UNFPA CO is part of the United Nations delivering as One and the Joint Programme on Data produces gender-disaggregated statistics in addition to RDHS and Census which inform planning and policy advocacy. The CO contributed to several United Nations reports such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), Universal Periodic Review (UPR), International Covenant on Economic, Social and Cultural Rights (ICESCR), and Voluntary National Reviews among others (Document reviews, KII and IDI).

During the current cycle, staff and partners benefited from capacity building on the MISP, disability

inclusion, protection from sexual abuse and exploitation, gender and disability inclusion, and budgeting. Held in partnership with UNDP, these trainings also included human rights reporting in partnership with the United Nations human rights task team. Age, sex and disability disaggregation are requirements for IP planning and reporting and help to understand the reach of UNFPA interventions. However, capacity for gender and human rights analysis is weak and impedes consistent gender and human rights-based planning and reporting (KII and IDI).

Renewed efforts have been made for inclusive planning and integration of persons with disabilities. Staff and IPs have been trained on the process while UNFPA also partnered with organisations of persons with disabilities for outreach and service provision. Training in sign language and provision for sign language services are part of UNFPA events. The recent launch of the sign language dictionary by the Government will strengthen capacity building and service provision. (Document reviews, KII and IDI).

A total of 44 gender-based violence centres have been established in partnership with the Government and the One UN and are based in district hospitals that facilitate referrals. standard operating procedures have been revised and disseminated. However, due to fear of stigma and long distances between the centres and communities, underreporting of gender-based violence remains a big issue. Data is collected through the health management information system (HMIS) and Rwanda Investigation Bureau. There is also a need to strengthen the Code of Conduct and referral mechanisms at school level where gender-based violence also takes place (Document review)

The conducive legal and policy environments are not matched by practice and change in social behaviours. More women than men are semi-literate, poor, sole heads of households, living in rural areas and survive on subsistence agriculture. This is why efforts have been invested in public awareness and education on progressive laws, policies and CSE, working with young minds to instil positive social norms. Consistent advocacy and multisectoral interventions are required for more progress to be achieved.

Communication system

This was another cross-cutting issue in the 8th CP, with a dedicated communication specialist charged to drive the communication plan of the CO. The CO developed a communication plan with clear-cut objectives and key performance indicators. The communication approach was aimed at leading the SRHR narrative, supporting UNFPA reports, research and building thought leadership.

The communication strategy of UNFPA CO is aligned with the 8th CP for the purpose of enhancing communication, advocacy and partnerships focusing on the three thematic clusters of the CP. The basic objective for a communications strategy for UNFPA Rwanda is to introduce a more organized approach to information sharing and targeting at all levels of the organization. For Rwanda CO, promoting the activities that encourage good health and well-being (SDG 3), promote gender equality (SDG 5) and reduce inequalities (SDG 10) is the pillar of the communication strategy. The sole aim of the communication strategy is to give human face to the challenges being faced by the different beneficiaries of the CP such as women suffering with fistula, pregnant women, adolescents, and youths. Documents and interviews from key informants show there is a synergy between the communication unit and other programme clusters, ensuring increased coordination and effective communication.

The communication strategies focused on advocating for the three transformative results and the

essential role of SRHR in strengthening health systems, mobilizing resources for the three zeros and population trends. The Communication Unit implemented its activities via social media, contributing to other websites, staff engagements, organizing media coverage of key events and outreaches, sharing UNFPA CO media mentions with Regional Office and HQ. Through its activities, the communication unit increased the CO social media presence by 75 per cent and contributed to ESARO's collective target of 350,000 followers, among others. One interviewee noted, *"Before I arrived in Kigali, I have noted the activities of UNFPA CO in Rwanda via its website and twitter handle…."* (IDI).

The communication activities are balanced between general communications activities (for key public events, key UNFPA priority national days and promotional activities, information/advocacy materials, and website and social platforms) and communication work in support of the four main programme components. The communication strategy has effectively addressed the need for web-based outreach; this includes maintaining the UNFPA website and development of social media. Based on interview findings with Rwanda CO Communication Unit, the CO assesses communication activities through careful monitoring of process measures such as media reporting following major public events and reporting on the numbers of visitors to UNFPA's online and social media platforms.

UNFPA uses advocacy as a tool of communication to tackle problems in partnership with government, NGOs, and civil society. The focus of its advocacy has been on mobilizing health workers for service provision to pregnant women, easy access to health facilities; advocating reduction of adolescent pregnancy, child marriage, female genital mutilation, and support to SSL for census sensitization. Despite the accomplishment and efforts of the Communication Unit, the Unit lacks budgetary allocation for its activities. Overall, the Communication Unit indicated 12 articles have been published to communicate 8th CP with at least two human interest stories on the UNFPA corporate website (Document review).

Resource mobilization and partnerships

During the 8th CP cycle, the CO developed a resource mobilization strategy and plan to inform and guide the CO towards sustainable financing of its 8th CP. The Resource Mobilization Plan attempted to provide an overview of the scale of the needs and resources needed to address them. The document proposed a fund-raising strategy and action plan which identified 11 sources of funding, out of which funds were raised from eight sources. The CO submitted eight proposals per year and conducted donor mapping on existing and potential new donors with a focus on non-traditional partners. CO mobilized $24 million. The Government of Rwanda's voluntary contribution to UNFPA regular resources was at $5000 annually.

In terms of partnerships, the CO established partnerships with donors, United Nations agencies and implementation partners to complete its agenda on SRHR. The donor partners are Switzerland (Swiss School of Tropical Public Health to implement SHR interventions); the Republic of Korea (improvising adolescents and young people); Japan (strengthening maternal health, SRH, gender-based violence) and Sweden (ensuring safe pregnancy and childbirths). Funds were mobilized from Japan to support the humanitarian response in Rwanda during the COVID-19 pandemic. In 2021, the flagship UNFPA Safeguarding Youth Programme was implemented in the three UNFPA-supported districts of Rusizi, Nyamasheke and Karongi. Another partnership involved One UN Joint Programme involving UNDP, WHO, UNHCR, UNFPA, which developed an initiative to support "1000 health posts in the land of 1000 hills" (Document review).

Implementation partners include ALIGHT, AHA, SFH, Imbuto Foundation. Such partnerships need to be extended to national institutions such as religious and traditional institutions.

One significant outcome of the strategy is the development of the new Strategic Investment Facility (SIF). The SIF is a move to support programme countries to shift from a development funding model to a financing model. It is a mechanism to leverage sums of domestic government resources, external funding, and investments from the private sector (Document review). The CO managed to prompt government allocations to government ministries and contributed to the procurement of family planning commodities. The Government of Rwanda committed funding support for the provision of family planning commodities and supported interventions through annual and in-kind contributions as identified in Strategic Investment Financing documents.

Monitoring and evaluation system

Robust M&E strategies are in place to track programme progress and outcomes. The M&E systems are designed to ensure full alignment with internal M&E, which includes the strategic information system (SIS), M&E tools have been designed by UNFPA for use by implementing partners to ensure compliance with donor reporting standards. The M&E framework of the 8th CP is anchored on the principles of results-based management which linked the CP to the relevant M&E systems such as coordination and reporting programmes, review meetings, mid-year and annual review and planning meeting, data collection and management, field monitoring visits and evaluation. M&E was guided by UNFPA procedures and guidelines. The M&E system integrates harmonized monitoring tools such as work plans and progress reports, field monitoring visit reports, CO annual reports and others. It was aligned to the CP Results and Resources Framework which defined a set of indicators with corresponding baselines, targets and means of verification.

In addition, the baseline and end-line data for several indicators were developed and targets set over the programme cycle. There were several indicators at outcome and output levels. At the output level, there are 14 indicators with baselines. All adolescents and youth and population dynamics indicators have baseline data. There was no indicator reference sheet to support the interpretation of indicators. Some indicators do provide precise and concise information on the degree of achievement, but others fall short. The programme indicators are measured through data collection by the IPs' programme and M&E staff on the field, reviewed by the CO programme staff before sharing with the CO M&E Specialist for reporting.

To track and review progress made in attaining planned activities, all IPs continued to use the work plan monitoring tool which facilitated reporting on a quarterly basis regarding progress towards achievement of annual targets as well as identifying facilitating and constraining factors. Similarly, to document progress on the achievement of CP outputs and outcomes, all IPs had to prepare and submit work plan progress reports on a quarterly and annual basis.

CO annual reports were prepared for each of the programme years of the 8th CP. These reports served an important function by providing the broad platform for taking stock of programme performance in relation to both internal and external threats. Annual reports highlight achievements, shortfalls in the implementation of CP action plans and annual work plans for each year as well as the most important interventions undertaken to achieve results. While evaluation of major programme outcomes is mandatory and significant to the M&E process, evaluation of major CP outcomes had not been conducted by the time of this evaluation. Data collection and management is another critical component of any M&E framework. In the 8th CP, IPs collect information on process indicators

relevant to the activities they implemented.

Innovation

According to document reviews, the 8th CP interventions have embraced innovative approaches such as mobile health technology for remote technical assistance, youth-friendly service delivery models and data-driven targeting of vulnerable populations. According to several documents, iAccelerator is a mentorship programme supporting young entrepreneurs with seed funding, training, and skills development to generate innovative solutions in response to challenges related to sexual and reproductive health, sexuality education, family planning, maternal and other population development issues in line with UNFPA's mandate. There are about 19 such technical innovations[86]. These innovations have not only improved service accessibility but also contributed to more effective resource allocation.

RapidPro system was developed to enhance real-time data monitoring of the community health programme.

A mobile learning system, known as MobiMenta, is an innovation used to increase skills and knowledge of in-service midwives using simulation material and hands-on practice with a mentor. Supported by Laerdal Global Health, the MobiMenta initiative has facilitated the continuous capacity-building model which allows the tailoring of training packages to the specific individual needs of the targeted health facilities.

The multi-award-winning Urukundo life-skills board and card game is available physically and digitally which provides evidence-based life skills information in friendly, interactive and inclusive fashion to young people everywhere.

Tantine App is a platform consisting of an Android application (Tantine App) and website (www.tantine.rw) which provides reliable sexual and reproductive health information in the Kinyarwanda language. Young people can also benefit from tools built into the platforms such as menstruation and ovulation tracker, BMI and due date calculator.

Vugukire Hotline Call Talking Cure (CTC) is a digital health-care platform that is addressing mental health problems by providing online therapy sessions done with confidentiality in a safe space. JoCare – Online/Mobile Platform for SRH Education is a friendly, educational Web app platform that allows young people, including those with disabilities, to discuss sexual reproductive health information through friendly, educational, online and offline innovative tools like JoCare Learn Board, girls' calculators, games, blogs, YouTube videos, using a web and mobile app.

UNFPA also supported the Rwanda National Council of Nurses and Midwives to develop and launch a web-based application that enables the Council to provide a platform to facilitate license applications, continuous professional development and monitoring the mobility of nurses and midwives. The application will increase the capacity of the Council to better collect and analyse data on human resources for health and increase evidence-based planning.

The Girls Take Over initiative, led by UN Women, aimed at providing a shadowing experience to

[86] Details of these technological iAccelerator can be found in Evaluation of Innovation Accelerator Programme Report submitted to UNFPA Rwanda CO.

young women in Rwanda. This draws from the evidence that having role models and career advice at an early age can be a game changer for young women and their achievements in the world of work. Through this initiative, 20 young girls spent half a day in various institutions and businesses with the view to getting first-hand professional experience and follow the daily responsibilities of leaders in various sectors.

UNFPA Rwanda CO supported the NISR to conduct the recently concluded census with digital technologies – computer assisted personnel interviewing and mobile technologies for data collection and analysis. It was the first time Rwanda used digital technology to conduct its national census.

During this 8th CP, CO introduced an innovation called MobiMentor which is a mobile initiative with structural similarities equipment that facilitates a capacity-building model which allows the tailoring of training packages to specific individual needs of the targeted health facilities. Through this initiative, 81 health care providers were trained to improve service delivery to health-care facilities.

Other innovative approaches include a resilience plan which involves introducing economic empowerment programmes within adolescent and youth SRH activities. This affords them the opportunity to learn skills and income generation activities for employment.

The First-Time Young Mothers is a unique model to deal with the challenges faced by these first-time young mothers. It uses intergenerational dialogue to resolve disputes between adolescents and their parents, and the involvement of religious leaders in promoting positive adolescent and youth sexual and reproductive health.

5. Conclusions

5.1 Strategic level Conclusions

Conclusion 1 – Relevance

It is evident that the UNFPA Rwanda 8th CP is aligned with, and designed to address, both local needs and regional and international development treaties. It is relevant to the NST1, HSSP IV and other national development priorities encapsulated in relevant national policies such as Ministry of Health FP/ASRH Strategic Plan, Ministry of Education National School Health Policy, the Ministry of Youth National Youth Policy and the National Gender Policy of the Ministry of Gender and Family Promotion. It is also aligned with Global UNFPA strategic plans and other international development frameworks such as ICPD Programme of Action and SDGs 2030. All strategies and policies prioritize stakeholders' needs which contributed to their relevance and effectiveness.

Origin: EQ 1; Evaluation criteria: relevance; Associated recommendation: R1, R2

The CP is aligned with the Rwanda National Strategy for Transformation (NST1), which is a reference document for development sectors. It is specifically aligned with the Pillar III of social transformation, intervention 60 to scale up efforts to raise awareness on reproductive health and family planning to increase contraceptive prevalence from 48 per cent (2013/2014) to 60 per cent in 2024. The two UNFPA Strategic Plans (2018–2021; 2022–2025), upon which the 8th CP is based, called for increased priority on SRHR and adolescents and promoted an integrated approach to SRH service delivery both for women and adolescents. The 8th CP responded to the strategic plan frameworks by increasing investment in adolescents and youth, especially young girls, and taking an integrated approach to SRH services and resilience plans. The Government of Rwanda prioritizes community health-care promotion and services, focusing on women, child health and nutrition as encapsulated in its health sector strategic plan and RMNCAH strategy. The Government makes financial contributions to some aspects of the 8th CP implementation especially in funding of family planning commodities provision. Integrated systems for SRHR and ASRH services have some elements in place. These include the RMNCAH, strengthening of CSE, peer education, and community involvement involving traditional and religious leaders.

Conclusion 2: Effectiveness

The 8th CP achieved expected results in five outcome areas and eleven output indicators. The SRHR and the adolescents and youth components of the 8th CP have recorded achievements in both development and humanitarian contexts through health systems strengthening and capacity building of health service providers and young people. UNFPA also effectively contributed to improved quality of population data. In supporting the 2022 Census, UNFPA increased national capacity to provide and use disaggregated data and analysis for policy, planning and data utilization for evidence-based planning. The effectiveness of the 8th CP interventions is made possible by a combination of strong political leadership, availability of successful replicable models and competent and skilled staff.

Origin: EQ 2; Criteria: effectiveness; Associated recommendation: R6, R7, R8, R9

In the SRHR component, UNFPA ensured improved access to sexual and reproductive health as well as prevention and response to gender-based violence. Capacity of the health workforce has been improved and UNFPA provided reproductive health commodities. There is success recorded in the implementation of CSE through programme interventions and youth participation in decision-making. Mechanisms for promotion of youth participation in decision making have been established in collaboration with the Ministry of Youth. The effectiveness of the 8th CP is made possible by a

combination of a strong UNFPA leadership, national political will, partnership with government and other United Nations agencies, and mobilization of resources and innovative financing models. The 8th CP is pitched at both upstream and downstream levels. Four outputs are driven by 19 strategic interventions to achieve three strategic outcomes.

Conclusion 3: A critical look at the theory of change shows a mismatch between the strategic interventions and the output indicators, casting doubt on whether the stated interventions would lead to the expected outcomes. The output indicators are not clearly linked with the strategic interventions. The analysis of the ToC found incomplete contribution of the outputs to the outcomes, incoherence and minor reflection between outcomes and indicators, lack of alignment and sufficiency in one outcome indicator and one output indicator, and a missing output indicator.

Origin: effectiveness; Evaluation criteria: effectiveness; Associated recommendation: R6, R7, R8, R9
While there was transition from the UNFPA Strategic Plan 2018–2021 to the new 2022–2025 plan, the CO did not implement the activities outlined in the CP.

Conclusion 4: Efficiency
There is efficient use of human and financial resources in the implementation of the 8th Country Programme. UNFPA policies and procedures were employed to the maximum in the implementation of the 8th CP interventions. CO used these for planning and monitoring of resource utilization. Both national and direct execution modalities were used where possible. Programme finance was managed well, to the extent that no qualified audit was reported. The CO employed innovative strategies to leverage and raise more funds, especially the Strategic Investment Facility, which was used to build and upgrade health posts innovatively applying the Public-Private Partnership model.

Origin: EQ3; C3; Evaluation criteria: efficiency; Associated recommendation: R3
UNFPA used a robust financial management and tracking system that facilitated programmatic and financial accountability. Regular follow up was made with implementing partners (IPs) for financial tracking, and no qualified audits have occurred. UNFPA managed to raise significant levels of financing from the private sector through the catalytic Strategic Investment Facility and from bilateral donors such as KOICA and the Safeguarding Youth Programme. UNFPA CO was creative and relatively efficient in fundraising for its interventions. Its business model of implementation through government and IPs, national execution and direct execution modalities enhanced implementation efficiency and enabled UNFPA to achieve more than 90 per cent of its indicators. IPs reported delays in fund as a common challenge, however, CO claimed this was due to the failure of IPs to follow guidelines in preparing project reports.

Disbursements were made based on satisfactory standard quarterly reporting. Most IPs reported that this worked well. All IPs reported challenges at year end when the reporting requirements are required much earlier than in other quarters. The Harmonised Approach to Cash Transfer (HACT) is in place and appears to work well. Inefficiencies identified include those caused by technical, operational and implementation issues (e.g. recruitment processes, lengthy procedures, and waiting for approvals by line ministries etc.).

Due to the shrinking development funding space, UNFPA collaboration with UNCT and other strategic stakeholders will be important to raise funds for investment in upstream interventions. UNFPA Rwanda CO mobilized additional financial resources from KOICA and the Strategic

Investment Facility (SDG Fund), Swiss Embassy, JICA and Regional Office Joint Programmes such as the Safeguarding Youth Programme. CO followed UNFPA policies and procedures in all activities including recruitment, implementation and report writing. There is inefficiency in terms of delay in disbursement of funds to IPs.

Conclusion 5: Coordination
Existing UNCT coordination mechanisms ensure a high level of coordination and cooperation among United Nations agencies in Rwanda. UNFPA plays an active and proactive role in planning, implementation and coordination of joint United Nations activities such as joint proposal development for 1000 health posts; Joint Programme on Data; United Nations thematic groups on communication, gender and youth; and interagency groups such as the UNSDCF Result Group 3 and M&E Task Team. This coordination and cooperation between resident United Nations agencies enables them to influence higher-level government systems and policies. For example, the Government's commitment to financing family planning commodities and support for 1000 new health posts are due to the agencies combining their technical and financial resources.

Origin: Q4; Criteria: Coordination and associated eecommendation:

5.2. Programme level Conclusions

Conclusion 6:
Sexual and reproductive health: This analysis shows that the various interventions such as midwifery capacity building, health system strengthening, and institutional capacity building have made a positive contribution to the reduction of maternal death. Maternal health is a medical issue with huge social ramifications, which demands mobilization of diverse actors in the country to further interventions holistically. In this context, social actors like traditional and religious leaders and psychosocial medical practitioners should be mobilized in the next cycle to participate in reducing maternal death, thereby contributing to the achievement of zero maternal deaths.

Adolescents and youth: The adolescents and youth interventions, including the roll-out of CSE manuals for both in-school and out-of-school of youth, development of youth-friendly corners and health centres, and promotion of income-generating activities at these centres, demonstrate sustainable and effective efforts to lead adolescents and youth on issues of SRH and gender-based violence. Youth-friendly corners and health centres are effective and efficient models to reach young people. The quality of peer-educators, the vibrancy of the youth-friendly corners and economic activities show an excellent innovative model for inclusive and participatory youth interventions.

Youth-friendly corners and health centres serve as highly effective and efficient models for delivering essential health services to young people. These specialized spaces are purposefully designed to meet the unique needs and preferences of youth, offering a welcoming environment where they can comfortably access a comprehensive range of health services. Tailored to address diverse health concerns, including sexual and reproductive health, mental health support, family planning, and general health education, these centres adopt a youth-centred approach, prioritizing confidentiality, non-judgmental attitudes, and respect for young people's autonomy in health decisions. Investing in these centres is crucial to bridging gaps in traditional health-care settings, ensuring age-appropriate and culturally sensitive services, promoting proactive health-seeking behaviours, and contributing to the overall well-being of young individuals. Such investments not only lead to immediate positive outcomes but also support long-term goals of healthier lifestyles, prevention of health issues, and the

establishment of trusting relationships between health-care providers and young people, aligning with broader sustainable development objectives.

Population dynamics: Capacity and systems for generation and utilization of population data for planning and programmes were strengthened leading to the production of the Rwanda Demographic and Health Survey 2019/2020 and Population and Housing Census 2022, and their use for policy planning and programming. The RDHS and Census have demonstrated UNFPA's comparative advantage in data and its effectiveness. UNFPA support enabled the development of statistical systems and capacity to produce quality data related to SDG indicators for planning, monitoring and advocacy.

Origin: EQ2; C2; Criteria: effectiveness; Associated recommendation: R6, R7, R8, R9, R11
SRHR and adolescents and youth interventions were relevant and effective to deliver SRH services in the targeted districts. Also, population dynamics interventions accomplished the set targets thereby achieving the outcomes and outputs.

Conclusion 7: **Connectedness**
UNFPA can respond to the need to address sexual and reproductive health in the intervention sites, especially among refugees. Most of the benefits of the 8th CP interventions on SRHR and adolescents and youth are enjoyed by the host communities as development dividend. Health posts and second-generation health posts are accessible to the host communities. The CO lacks an overarching strategy to address any emergency crisis.

Origin: EQ6; Criteria: Connectedness; Associated Recommendation: R1, R6, R7, R8, R9, R11

Conclusion 8: Gender equality and human rights, resource mobilization, communication, M&E, and innovative systems were developed and cut across the outcome areas of the 8th CP. Gender equality and human rights mainstreaming is indicated but no specific programme interventions exist. Innovative strategies were developed to accelerate activities across the three outcome areas. The M&E system is aligned with a direct output-outcome relationship but the indicators in the CP Results Framework do not capture the results of some of the strategic interventions. Earlier in the in the programme, communication was active but lacked proper funding support, however in more recent years, this trend has changed. There is no permanent M&E support system. There are great innovations introduced in the programme. All cross-cutting themes lack substantive technical units, funding support and measurable indicators.

Origin: EQ6; Criteria: Cross-cutting issues; Associated recommendation: **13**
The strategic interventions lack precision to help identify action plans and activities and their linkages in the achievement of the output. A more focused identification of the strategic interventions associated with these issues will capture activity results.

6. Recommendations

6.1. Strategic level

Recommendation 1: The next CP should be more focused on a joint, integrated programming approach across all development programme outcomes. This should be accompanied with a ToC that encompasses the entire results chain ensuring adequate skills and capacity of staff that participate in the formulation of the results framework.

Priority: High; Target: CO, UNCT; Conclusion: C1, C2
Operational implications: CO should continue to build on the experiences gained from the 8th CP in three thematic areas. It should also continue joint programming with other United Nations agencies. The CO and partners should advocate for adolescent use of SRH services for screening rather than treatment, thereby making effective use of the peer educators. The next CP should also extend the ASRH programme to other districts, especially in Eastern Province where adolescent pregnancies are very high. More weight should be given to advocacy, policy dialogue and technical assistance in implementation of the next CP. The ***financial implication*** is the need to source additional funds to advance the interventions. In terms of ***human resource implications***, more staff will be needed to extend the activities to other districts and implement upstream interventions.

Recommendation 2: Strategic partnership is crucial to provide quality, holistic and integrated services and delivery standards needed in Rwanda. UNFPA's strategic partnerships with IPs that have proven comparative advantages and expertise in SRHR, HIV, gender-based violence, education, and disability, and partnerships with political leadership at both central and district levels, promotes and strengthens sexual and reproductive health and rights for all. Strategic partnerships should be extended in different upstream interventions.

Priority: High; Target: CO, UNCT, IPs, GoR; Timeframe: long-term; Origin: C1, C2
Operational implications: The CO should maintain relevant strategic partnerships with key government ministries, departments and IPs and step-up its leadership role supporting the government with strategy and policy development, advocacy and technical assistance. There should be skill enhancement in the CO covering leadership, advocacy and policy dialogue. All avenues should be explored for joint programme activities with United Nations agencies and other strategic partners in support of future programme priorities. Major joint programme initiatives at the district levels that address common objectives and activities towards achieving the three zeros should be intensified. The CO should continue to work with religious leaders and other influential leaders to promote the three zeros. The ***financial implication*** is additional funds will be required to intensify joint activities and reach the farthest districts, and the ***human resource implication*** is more personnel will be needed to implement these activities.

Recommendation 3: Since the focus of the 8th CP in Rwanda is on upstream interventions, UNFPA human and technical resources should be relevant to promote advocacy on emerging national development needs. Technical support, financial efficiency, policy dialogue, strategic information, joint United Nations work and sustainable solutions for upscale programming are needed to increase staff capacities to provide adequate support for the integration of ICPD Programme of Action issues within the broader Agenda 2030 and UNFPA mandate.

Priority: High; Target: CO, UNCT, GoR; Timeframe: medium-term; Origin:C3

Operational implications: The CO should initiate human resource mapping to identify the staffing gaps and priorities that need strengthening in line with Agenda 2030 and next CP. It should also identify funding gaps and opportunities required to support the resulting revisions to the human resources structure; explore out-of-the-box thinking methods to mobilize resources; leverage innovations across UNFPA and with strategic partners to amplify the impact; support established IPs to scale up successful interventions and exploit UNFPA's technical niche in SRHR, data generation and advocacy to mobilize resources. The ***financial implication*** for these activities remains the need to secure additional funding to address the ***human resource implications*** since skills mapping will reveal missing skills that need to be acquired to be able to deliver efficiently on the next CP.

Recommendation 4: Continue support to develop systems to generate and use population data. There should be strategic interventions to make data accessible and available for evidence-based planning and policy-making in all programme areas.

Priority: High; Target: CO, GoR; Timeframe: medium-term; Conclusion: C2
Operational implications: UNFPA should continue to support the building of national capacities for data collection, analysis, dissemination, and utilization and increased availability of disaggregated quality data for evidence-based policymaking, planning, implementation, M&E. It should use surveys and census data to generate a body of evidence related to the UNFPA mandate and use this evidence to generate evidence-based policy briefs that would serve for advocacy purposes and strategic analysis. UNFPA should conduct workshops on how to use and integrate data in national and district development planning and provide technical assistance to districts on appropriate use and interpretation of demographic indicators for policy and planning. These have ***financial and human resource implications*** as additional funds and personnel will be needed to implement these activities.

Recommendation 5: UNFPA human and technical resources are of critical importance to advance the in-country programmatic and advocacy agenda and remain relevant to cover the emerging national development priorities. Due to the business model for Rwanda involving advocacy and partnerships, technical support, and coordination for the ambitious 2030 Agenda, UNFPA should have strong comparative advantage and presence in the country.

Priority: High; Target: CO, GoR, UNCT; Timeframe: medium-term; Origin: C4, C5
Operational Implications: UNFPA should conduct a skills-mapping exercise to identify the staffing gaps and potential programming areas that need strengthening and identify funding gaps and opportunities for the reviewed human resources structure. The ***financial implication*** is that additional ***human resources*** will be needed to fill the identified skills gaps.

Recommendation 6: A more meticulously designed theory of change needs to be formulated with a sound causal framework as well as robust and coherent elements, matching the outputs with the interventions and outcome indicators.

Priority: High; Target level: CO; Timeframe: medium-term; Origin: C2
Operational implications: The strategic interventions should be operationalized and made measurable. The CO should also retrain staff and position them for full-scale upstream interventions. The ***financial implication*** is that it will require additional funds to retrain or hire new staff.

Recommendation 7: UNFPA CO should consolidate and expand the work with parliamentarians and policymakers. It needs to invest resources to consolidate and expand its policy advocacy efforts and

competencies to maintain a favourable legal climate for SRH including HIV, gender-based violence, adolescents and youth, population and development activities. As these are upstream interventions, greater investment in technical advisory support is needed provide systematic analysis of existing strategic documents as well as in drafting of new strategic policies, guidelines, and manuals.

Priority: High; Target: CO; Timeframe: long-term; Origin: C2
Operational implications: CO should design and increase investment in advocacy work that transcends all programme areas. More staff should be recruited and trained to be capable of implementing advocacy and technical capacity building. The ***financial and human resource*** implications of these are obvious.

6.2 Programme Level

Recommendation 8: In the next CP, the SRHR component should continue to be aligned with national priorities and international commitments related to maternal health and family planning as elaborated in several national policies and international frameworks. The CP should be focused on an integrated programming approach.

Priority: High; Target: UNFPA CO, GoR, IPs, donors; Timeframe: long-term; Origin: C2
Operational implications: For maternal health, all current activities can be continued in the next CP by collaborating with the relevant ministries and IPs. Capacity-building interventions and health systems strengthening should also be continued. UNFPA should encourage national IPs to present and share their experiences at national and international events to stimulate public use of maternal health data. Programmes should be accompanied by theories of change that encompass the entire results chain, ensuring staff who participate in the formulation of the results framework have adequate skills and capacity. UNFPA should explore joint programming with other United Nations agencies to maximise its competitive advantage for available resources. The ***financial implication*** is that greater financial resources will be needed to fund these while the ***human resource implication*** is that more capable personnel will be needed.

Recommendation 9: Sexual and reproductive health
More attention is needed to support all national SRH and family planning strategies for the next programme cycle that will address issues of staff competence and community-level demand creation. CO needs to strengthen strategic partnerships with policymakers, NGOs, South-South partnerships, including national public-private partnership to leverage human and financial resources to achieve universal access to family planning. The One UN initiative to build 1000 health posts should be intensified. CO should assist the Ministry of Health to ensure that existing mechanisms for ensuring access to SRH, family planning and gender-based violence services are functional. UNFPA should continue to contribute to the capacity development of the Rwanda Association of Midwifery to improve and sustain quality of care on all levels and strengthen midwifery regulation mechanisms to permit an expanded role for midwives in SRH, family planning and gender-based violence service delivery. Investments should be made in improved monitoring and setting up a supporting supervisory system. UNFPA should enhance access to family planning services in rural areas, sociocultural barriers and stigmas surrounding family planning, gender inequalities, and power dynamics within relationships, and strengthen robust M&E systems.

Priority: High; Target: CO and IPs; Timeframe: long-term; Origin: C1, C2, C3, C4, C5
Operational implications: CO and partners should prioritize maternal mortality, gender-based

violence reduction and reduction of unmet need for family planning as key agenda for government engagement, accompanied by high-level advocacy and strong governance. The CO should foster collaboration with various government entities and multiple stakeholders to enhance ownership ensuring the sustainability of interventions aimed at improving maternal health outcomes. CO and IPs should also expand the use of information technology which presents tremendous opportunities for capacity building, expedited referral systems, and telehealth options to broaden the reach and impact of maternal health initiatives. The ***financial implication*** is the funds needed to invest in interventions to promote the three zeros, while the ***human resource implication*** requires recruitment of tech-savvy personnel to handle the IT-led interventions.

Recommendation 10: Adolescent and youth development
In the next CP, there is need for greater support to strengthen the capacity of educational staff and school- and community-based peer education clubs for CSE. Although much was done to promote CSE both in and out of schools, the findings showed that much is still to be done in terms of the number of adolescents and youth are yet to be reached. The focus should be on training teaching staff in primary and secondary schools as well as in TVET, training master trainers and strengthening their capacity to organise training sessions for their colleague teachers, developing materials, and multiplying peer education clubs within and out of schools and strengthening their capacity to function.

Priority: High; Target: UNFPA CO, GoR Ministries (Education, Health, Gender, Youth) and IPs, Development partners; Timeframe: long-term; Origin: C1, C6.
Operational implications: UNFPA should also continue to partner with key institutions, civil society organisations and youth organisations to promote CSE among youth. CO should support the development of policies and strategic plans within key development sectors at national and provincial levels in the next NST with the focus on CSE. It should also develop a standard operating procedure to facilitate the development and running of school-based health clubs. Intergenerational dialogue and involvement of religious leaders in adolescents and youth programmes should be continued. CO and IPs should set up a national platform to monitor the establishment and implementation of guidelines for CSE. The ***financial implication*** is to allocate funds to drive all the processes, especially at the district level. The **human *resource implication*** involves hiring technical assistants to develop new innovations to address adolescents and youth needs.

Recommendation 11: CO should continue to diversify resource mobilization in the country, going beyond established partnerships and traditional funders, especially in the face of shrinking funding space for development programmes.

Priority: High; Target: CO; Time Frame: long-term; Origin: C3.
Operational implications: CO should continue to explore more non-traditional sources of funding, especially the Strategic Investment Facility, and continue leveraging the Strategic Investment Financing models with strategic partners to amplify the impact. Resource mobilization should be done with IPs, government, and non-government partners. ***The human resource implication*** is the need to have a dedicated team to be professional fundraisers, developing ideas to market to non-traditional sources.

Recommendation 12: Population dynamics
UNFPA CO should continue providing technical support to NISR for the preparation of the national census and demographic and health survey**.** UNFPA should support the National Development of

Statistical System Strategy which provides for an integrated statistical system to produce improved quality of data related to population and other components of the CP. It should also support advocacy and coordination for the implementation of ICPD Programme of Action, SDG 2030 and the current UNFPA Strategic Plan 2022–2025.

Priority: Very High; Target: CO, NISR, UNCT; Timeframe: long term; Origin: C1, C2, C3, C4, C5
Operational implications: CO and NSR should begin to operationalise the National Development of Statistical System. UNFPA should continue to support the building of national capacities for data collection, analysis, dissemination and fostering the use of data to inform evidence-based policies. It should continue to support increased availability of disaggregated quality data for evidence-based policy making, planning, implementation, monitoring, and evaluation. CO should advocate for training and career development of young demographers and statisticians, especially training in the newer technologies of data analytics, and raise awareness of the importance of statistical and demographic data for planning and monitoring population developments. UNFPA should provide technical support for the integration of population dynamics into national development and support advocacy to promote the understanding of population dynamics through seminars, conferences, and workshops. The ***financial implication*** is that to accomplish these recommendations requires huge financial investment to recruit consultants who will deliver, as well as funds for training statisticians and demographers in modern analytical techniques.

Recommendation 13: All cross-cutting issues and principles should be mainstreamed with more focus on advocacy and technical assistance.

Priority: High; Target: CO and IPs; Timeframe: short term; Origin: C1, C2, C3, C4, C5
Operational implications: CO should develop strategies that will define the mainstreaming of those cross-cutting issues, including advocacy strategy. The ***financial implication*** will be the funds required to hire advocacy personnel and to develop a full M&E unit in the CO. ***Human resource implications*** include additional staff to drive the mainstreaming of the principles and a dedicated staff for M&E and advocacy.

Lessons learned
The 8th CP has offered valuable lessons for both UNFPA and government authorities. Key lessons for UNFPA include the importance of fostering local ownership, aligning programme strategies with national priorities, and ensuring unified coordination among stakeholders. Government partners have sharpened the significance of multi-sectoral collaboration, data-driven decision-making, and the integration of human rights-based approaches into SRHR intervention. Other lessons learned from the implementation of the 8th Country Programme include:

- Rwanda's success in the 8th CP implementation can be attributed to the strong commitment demonstrated by the Government, which integrated SRH and family planning into national policies and strategies. SRH and family planning services are integrated into other health-care services, such as antenatal care, maternity and HIV/AIDS programs, to ensure comprehensive care.

- A multi-sectoral approach is very successful and sustainable. This was observed in the way vulnerable adolescents and youth were supported in small business. While they were meeting for an income-generating activity they were simultaneously being skilled and empowered in making informed decisions concerning SRHR. Other findings show that campaigns which are

accompanied by services (condom distribution, STI tests…) are successful. Therefore, a combination of two or more kinds of activity is more successful than just one activity.

- Involving rights-bearers and other people at the community level ensures sustainability. The interventions of UNFPA were rooted in district plans. Working in close collaboration with local community (leaders and beneficiaries) gives hope of sustainability of the outputs and of continuation of the initiated activities even when IPs exit.
- The mentorship approach has proved its cost effectiveness in improving EmONC service delivery. This, however, requires strong support at the beginning to ensure quality and the establishment of a strong monitoring system to track improvements in quality of care.
- Innovative approaches can greatly contribute to quality improvement of midwifery skills towards reduction of preventable maternal deaths. For example, mobile learning system innovation is very effective in ensuring continuous professional development of midwives and other frontline health workers in a more efficient and sustainable manner. In Rwanda, it worked well due to leveraging the existing 'morning all-staff meeting' and adding group learning sessions according to the workload at that health facility. Ownership by the Ministry of Health and establishment of district-based mobile learning system committees were key enablers of the successful implementation.

- Building community engagement and ownership by involving community leaders, religious institutions, and local organizations in raising awareness and providing accurate information about family planning helped build trust and overcome cultural barriers.

- Rwanda established a wide network of service delivery points, including health centres and community health posts, to improve access to SRH and family planning services, particularly for rural populations.

- By training nurses and midwives to provide SRH and family planning services, Rwanda addressed the shortage of health-care professionals, improving access and reducing the burden on dedicated SRH and family planning focal points.

- The programme leveraged partnerships with the private sector, non-governmental organizations and international agencies to expand the reach of family planning services. Collaboration with these entities helped to mobilize additional resources, strengthen service delivery, and enhance programme sustainability.

- Rwanda has focused on providing youth-friendly SRH, family planning services and reproductive health education to address the needs of adolescents and young adults.

Annexes

Annex 1: Evaluation matrix

<table>
<tr><td colspan="3">Evaluation Question 1: To what extent does the UNFPA Rwanda 8th Country Programme align with Rwanda's development priorities; UNFPA's global strategic plans; and the needs of the intended beneficiaries namely women, young people, vulnerable populations including people with disabilities and other key populations?</td></tr>
<tr><td colspan="3">(The extent to which the 8th CP corresponds to population needs at country levels in particular those of vulnerable groups, and was aligned throughout the programme period with government priorities and with strategies of UNFPA).</td></tr>
<tr><td colspan="3">Evaluation Criteria: [Relevance]</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td rowspan="2">Assumptions for verification 1.1: Needs of Targeted beneficiaries (diverse populations including marginalised and vulnerable populations were identified and taken into account in the 8th Country Programme</td><td>Indicators:</td><td>Methods and tools for data collection:</td></tr>
<tr><td>I.1: Evidence that the needs of the Rwanda population in general and needs of the most vulnerable populations groups were analysed to inform the design of 8th CP</td><td>● Document Review
● Interviews with UNFPA CO staff, Implementation Partners, and 8th CP beneficiaries</td></tr>
<tr><td colspan="2">Data collected</td><td>Source</td></tr>
<tr><td colspan="2">By 2023, people in Rwanda, particularly the most vulnerable, enjoy increased and equitable access to high-quality education, health, nutrition, and WASH services, and by 2023, people in Rwanda, particularly the most vulnerable, have increased resilience to both natural and man-made shocks for a life free from all forms of violence and discrimination.</td><td>MIDTERM REVIEW OF THE 8th UNFPA RWANDA COUNTRY PROGRAMME (2018–2023) and Interviews with UNFPA CO staff</td></tr>
<tr><td colspan="2">Additionally, significant world days, such as World Contraception Day (in September 2022) and World Disability Day (in December 2022), were commemorated in the three key districts identified as having the lowest family planning uptake in the country. During these 15 days, approximately 4,000 clients had the opportunity to access family planning services. These outreach campaigns were designed to uphold the UNFPA's principle of inclusivity, ensuring that no one is left behind, especially Persons with Disabilities (PWDs). PWDs received accurate information regarding the availability and accessibility of reproductive health commodities and family planning services. A total of 21 participants from 19 healthcare facilities, including these districts in Rusizi, Nyamasheke, and Karongi, improved their expertise in delivering services tailored to key populations.</td><td>2022–2023 UNFPA Annual Review Workshop with Partners and Interviews with UNFPA CO staff</td></tr>
<tr><td rowspan="2">Assumptions for verification 1.2: 8th CP was adapted to or aligned to national development strategies and policies?</td><td>Indicators:</td><td>Methods and tools for data collection:</td></tr>
<tr><td>I.1: Extend of alignment between 8th CP priorities and priories in national development strategies and priorities</td><td>● Document Reviews</td></tr>
</table>

	I.2: Extent of alignment between CP outcomes and priorities set in national strategies and plans in the three areas of the 8th CP	• **Interviews with UNFPA CO staff**
The 8th Country Programme is well-suited to integrate within the broader national development framework, including the UNFPA strategic plan that reaffirms the relevance of the current strategic direction of UNFPA. It calls for urgent action to achieve universal access to sexual and reproductive health, and realize reproductive rights for all). It aligns with various policies and strategic plans within the healthcare sector, such as the FP/SRH Strategic Plan), the Reproductive Health Strategy, and other complementary strategies addressing human resources for health, midwifery training, and the management of obstetric fistula. UNFPA Rwanda, in cooperation with the Ministry of Health and various stakeholders, has played a leading role in facilitating the creation of several crucial initiatives. These include the inaugural comprehensive RMNCAH (Reproductive, Maternal, Newborn, Child, and Adolescent Health) Policy spanning from 2017 to 2030, the Family Planning and Adolescent Sexual and Reproductive Health (FP/ASRH) Strategic Plan spanning from 2018 to 2024, the development of a Demographic Dividend Profile, and support for social entrepreneurship through the Innovation Accelerator (iAccelerator) programme and the Mobile for Reproductive Health (m4RH) program, particularly aimed at youth.		Interviews with UNFPA CO staff, UNCT staff and The UNFPA's strategic plan 2022 – 2025, and Country office annual reports
National and subnational institutions have enhanced capacities to develop and implement strategies, guidelines and standards for increased access to information and services on sexual and reproductive health and reproductive rights. National and subnational institutions have enhanced capacities to effectively deliver integrated, youth-friendly SRH services, including to key populations and in humanitarian situations. UNFPA Rwanda, in cooperation with the Ministry of Health and various stakeholders, has played a leading role in facilitating the creation of several crucial initiatives. These include the inaugural comprehensive RMNCAH (Reproductive, Maternal, Newborn, Child, and Adolescent Health) Policy spanning from 2017 to 2030, the Family Planning and Adolescent Sexual and Reproductive Health (FP/ASRH) Strategic Plan spanning from 2018 to 2024, the development of a Demographic Dividend Profile, and support for social entrepreneurship through the Innovation Accelerator (iAccelerator) programme and the Mobile for Reproductive Health (m4RH) program, particularly aimed at youth.		UNFPA Rwanda 8th Country Programme and Results Resources Framework, Interviews with UNFPA CO staff, UNCT staff, and Country office annual reports
Assumptions for verification 1.3: 8th CP outputs and outcomes as well as interventions are consistent with SDGs, ICPD Programme of Action and UNSDCF	**Indicators:**	**Methods and tools for data collection:**
	I.1: Extent of alignment between CP outcomes and priorities set in national strategies and plans in the three areas of the CP	**Document review**
	I.2: Extent of alignment between 8th CP and	**Interviews with UNFPA CO staff,**

	UNFP SPs 2018–2021 and 2022–2025	**UNCT staff**
	1.3 Extent of alignment between CP outputs, projects and planned activities set in Strategic Plans	**Interviews with National Stakeholders like Ministry of Health, RBC**
	1.4 Extent of alignment between operational modalities used for 8th CP implementation and business model defined by the SP	**Interviews with UNFPA CO staff, UNCT staff**
	1.5 Extent of alignment between 8th CP outputs and Rwanda UNSDCF 2019–2024	**Document review**
The SRH components of UNFPA's 8th Country Programme are closely tied to both local and global initiatives aimed at improving access to evidence-based interventions for sexual and reproductive health (SRH) issues. The SRH-related interventions within this component align seamlessly with the key priorities outlined in the International Conference on Population and Development (ICPD) Programme of Action, the Sustainable Development Goals (SDG) Agenda 2030. By 2023, people in Rwanda, particularly the most vulnerable, enjoy increased and equitable access to high-quality education, health, nutrition and WASH services. Indicators: Contraceptive prevalence rate. Baseline: 47.5; Target: 57. Percentage of pregnant women receiving four antenatal care contacts. Baseline: 44; Target: 51. By 2023, people in Rwanda, particularly the most vulnerable, have increased resilience to both natural and man-made shocks for a life free from all forms of violence and discrimination. Indicator: Percentage of women aged 15–49 years who have ever experienced sexual violence. Baseline: 35; Target: 15		**Interviews with UNFPA CO staff, UNCT staff,** UNFPA Strategic Plans for 2014–2017, 2018–**2021,and 2022–2025**,
Information gathered from interviews with stakeholders indicated the relevance of UNFPA's 8th Country Programme in Rwanda for sexual reproductive health remained its alignment with the specific needs and challenges related to sexual and reproductive health (SRH) in Rwanda. This programme likely addressed critical SRH issues that the Rwandan population faces, such as maternal and child health, family planning, access to reproductive healthcare services, gender-based violence prevention, and CSE in rural areas.		**Interviews with UNFPA CO staff,**
In the context of Delivering as One, UNFPA Rwanda Country Programme became fully aligned with the United Nations Development Assistance Plan (UNDAP) through which the development partners in Rwanda work towards common goals and results. As the UNDAP (2013–2018) shifts to the next generation for the period of 2018–2023, Development Results Groups (DRGs) in four outcome areas have been realigned to Results Groups (RGs) in three outcome areas. United Nations Development Assistance Framework (UNDAF) for the period 2016–2020. The efforts also resonate with the transformative and people-centric outcomes set forth in UNFPA's strategic plans for 2014–2017 and its revised plan for 2018–2021. The output and outcome of the		UNFPA SRH Unit Lead (Marie Claire Iryanyawera), RBC - MCCH Division, Director of Health Facility Programs Unit (Dr Francois Regis CYIZA), Midwifery School (Tengera Olive), Health Development Initiative, Research Director (Louange Twahirwa, and Rwanda Association of Midwives

SRH component is evidently connected, as anticipated, to the United Nations Agenda 203, SGDs, UNFPA's vision to eliminate avoidable maternal fatalities and fulfil the unmet demand for family planning. The UNFPA Strategic Plans for **2018–2021 and 2022–2025**, along with the SRH segment of the 8th CP, proved relevant in tackling the pressing sexual and reproductive health requirements of Rwandans.	(RAM), President, Josephine Murekezi, and Alight programme coordinator (Chantal Uwambaza
The Country Office (CO) has addressed emergencies that occurred during the 8th Country Programme (CP) period. The CO's humanitarian efforts include assistance to refugees displaced and affected by conflicts in DRC and Burundi. UNFPA partnered with MINEMA and provided support to refugee camps and local healthcare facilities in host communities to ensure the availability of sexual and reproductive health (SRH) services for communities in crisis situations.	**Interviews with UNFPA CO staff, UNCT staff**
National and district-level financial sustainability plans for family-planning services available Baseline: No; Target: Yes, Updated and revised guidelines on adolescent sexual reproductive health, family planning, maternal, neonatal and child health, HIV/STIs and gender-based violence available and disseminated Baseline: No; Target: Yes, Number of midwifery schools using a standardized competency-based academic curriculum Baseline: 4; Target: 7 Proportion of service delivery points without stock-outs Baseline: 93; Target: 96, Percentage of health centres in the target districts that provide youth-friendly services as per national standards Baseline: 29.5; Target: 50, Percentage of female sex workers accessing sexual and reproductive health and HIV services in target districts (for Rusizi, Nyamasheke and Karongi, respectively) Baselines: 50, 50 and 79; Targets: 70, 70 and 95, Number of refugee camps with adolescent SRH services. Baseline: 2; Target: 5	UNFPA Rwanda 8th Country Programme and Results Resources Framework,

ADOLESCENTS AND YOUTH (AY)		
Assumptions for verification 1.1: Needs of targeted beneficiaries (diverse populations including marginalised and vulnerable populations) were identified and taken into account in the 8th CP	**Indicators:** I.1: Evidence that the needs of the Rwanda population in general and needs of the most vulnerable populations groups were analysed to inform the design of 8th CP	**Methods and tools for data collection:** Document Review Interviews with UNFPA CO staff, Implementation Partners and 8th CP beneficiaries
Data collected		***Source of information***
Needs assessment was conducted before the interventions start and the findings were taken into consideration during the design. For example an assessment was conducted in 2018 on SRH.		KII with CO
The selection of beneficiaries is systematically done with priority to the most in needs. In Mahama camp, supported adolescent mothers are those whose household size is bigger. Peer educators and ALIGHT organisation work in close collaboration with the leaders of villages/quartiers to select such categories of		FGD with IPs

people. After consulting these leaders, a more deep analysis of these families is done before deciding on a particular beneficiary.	
UNFPA conducted a study on adolescent pregnancies which helps to decide The needs of the targeted population are identified through: regular needs assessment conducted in the community (as part of planning activities); Beneficiaries express their needs as participants during regular assessments conducted and during the planning meetings (when preparing strategic plans); We organise participatory planning where the community is consulted before determining the interventions at (development) sector level We talk with beneficiaries in order to identify their real needs. We are based in the community, we work with groups, family friends [Inshuti z'Umuryango/IZU], local leaders. Regular meeting and discussion with services providers (health workers) to ensure that services are appropriate with the beneficiaries' needs; Regular supervision of the work within institutions and communities (district leaders, district hospitals, beneficiaries…) We co-create together with the youth through dialogues and FGD with them We work with (we consult) youth's organisations all over the country and hear their needs We consult technical working groups before we decide on interventions We plan and discuss with church leaders who are with community beneficiaries' day to day. They have youth movements and youth departments, Referring to the strategic plan of Health Sector which was established in partnership and with participation of all stakeholders expressing their needs from the community level upward. All the subsequent annual plans refer to this document	IDI with IPs
The youth are involved in the implementation (and evaluation) of programmes, their needs are expressed during that process and activities adjusted accordingly E.g. AfriYAN (Umbrella of Youth Led organisations)	KII with CO
We are not considering the stages of the needs of the beneficiaries. We are pushing them quickly at an excessive pace, especially in rural areas. Example why send 50 computers in Nyamasheke districts before training them how to use computers or without organising such a training concurrently? We consider them as if they were in the City of Kigali. There is a clash between the district plan and related performance contracts on the one hand and the needs of the youth on the other hand, and moreover with the agenda of NGOs and UNFPA. Sometimes NGOs are forced to fall into the districts' agenda without any consultation of the beneficiaries Districts are consulted but not the youth for economic support. Thus NGOs just spend/waste the money. They decided in the intervention to the youth and they gave them what they do not need. District leaders decide that the youth should be given sewing machines, goats while these youths are not consulted. Some would not even	IDI with IPs

use the skills they were given because it is in their interest (while the money is spent already). However, no cooperative was formed for these youth. They only look at material distribution without looking at long term impact. Imbuto Foundation as well is not consulting the youth, thus the youth innovations that they ate supporting are not adapted to the needs of the youth. Not all funded projects are working well, some beneficiaries even withdrew themselves from it. So youth need to be capacitated and engaged		
Assumptions for verification 1.2: 8th CP was adapted to or aligned to national development strategies and policies	**Indicators:** **I.1: Extend of alignment between 8th CP priorities and priories in national development strategies and priorities** **I.2: Extent of alignment between CP outcomes and priorities set in national strategies and plans in the three areas of the 8th CP**	**Methods and tools for data collection:** Document Reviews Interviews with UNFPA CO staff [Interviews with IPs]
Data collected		***Source of information***
CPD contributed to the national instruments and policies (CPD doc) [87] *These include the Vision 2020, National strategy for transformation (NST1,), Health Sector strategy 2018–2024),* s new Reproductive, Maternal, and the New-born, Child and Adolescent Health Policy (2017–2030). The previous programmes' evaluation results were taken into account as well, as well as the previous population census. The selection of the AY component and the focus on the three districts of Karongi, Nyamasheke, and Rusizi was informed by the CP7 evaluation, where UNFPA had achieved all targets in the focus districts, except in these three districts, where contraceptive prevalence and skilled birth attendance rates were still below the national average. CP also included government institution such as Ministry of Youth, RBC, MoH…		UNFPA (2018) Doc
Referring 7 year Rwanda Country programme known as National Strategy for Transformation (NST1) which is a country guideline for the period 2017–2024. With this document, SRH, adolescent pregnancy, family planning are among the priorities, especially in reference with the key strategic intervention No 60: *"…ensuring universal access to contraceptive information and services to avoid unplanned pregnancies and prevention of sexually transmitted diseases with a particular focus on the youth"* [88] (NST1, p30)		IDI with IPs; NST1 Doc KII with CO
Most of interventions refer to NST1, for example, bring health services closer to the population, peer education, free services, etc. We refer to the national priorities – from there we select our priorities together with UNFPA We refer to the strategic plans and policies in health sector and Ministry of health We organise regular meetings and discussions at national level to ensure the alignment of interventions with		IDI with IPs

[87] UNFPA (2018). Country programme document for Rwanda July 2018-June 2023. UNFPA.
[88] Republic of Rwanda (2017). 7 Years Government Programme: National Strategy for Transformation (NST1) 2017–2024 (p30)

national priorities Youth, SRH, youth corners, adolescent mothers and other youth, all these topics and concerns are part of national priorities		
National surveys like RDHS are referred to in planning and implementation UNFPA refers to UNDAP, which is a United Nations National Plan; this UNDAP also refers to national priorities		KII with CO
Assumptions for verification 1.3: 8th CP outputs and outcomes as well as interventions are consistent with SDGs, ICPD Programme of Action and UNSDCF	**Indicators:** **I.2: Extent of alignment between 8th CP and UNFP SPs 2018–2021 and 2022–2025** **1.3 Extent of alignment between CP outputs, projects and planned activities set in Strategic Plans** **1.4 Extent of alignment between operational modalities used for 8th CP implementation and business model defined by the SP** **1.5 Extent of alignment between 8th CP outputs and Rwanda UNSDCF 2019–2024**	**Methods and tools for data collection:** Document review Interviews with UNFPA CO staff, UNCT staff Interviews with National Stakeholders like Ministry of Health, Youth, Rwanda Education Board, National Institute for Statistics etc.
Data collected		***Source of information***
The strategies and interventions support and contribute to the achievement of SDGs and ICPS POA. Since these instruments are quoted in NST1 (2017–2024) as references and guide, this is an assurance that they were faithfully integrated. **SDGs** are referred to in the first instance, then the national priorities and beneficiaries' real needs		IDI with IPs Document review

Evaluation Question 2: **To what extent the 8th CP outputs have been achieved and the extent to which these outputs have contributed to the achievement of the country programme outcomes?**		
Evaluation Criteria: [*Effectiveness*]		
SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS		
Assumptions for verification 2.1: *Planned outputs were achieved and contributed to outcome results*	**Indicators:** **I.1: Evidence of achievement of CP output targets**	**Methods and tools for data collection:** • **Documents review**

in SRHR	**I.2: Utilization of the outputs of the 8th CP to contribute to outcomes results**	● **Interviews with Key informant, UNFPA CO staff, Implementation partners,**
	1.3 Extent of implementation of planned activities towards output indicators for the 8th CP	● Focus **group discussions with beneficiaries** **Visits to Intervention sites at districts.**
Output 1: National and subnational institutions have enhanced capacities to develop and implement strategies, guidelines and standards for increased access to information and services on sexual and reproductive health and reproductive rights. UNFPA 8th CP assisted in the efficient execution of the Reproductive, Maternal, Newborn, Child, and Adolescent Health Policy by employing the following approaches:		
Collaborate with the Ministry of Health to revise, formulate, and disseminate gender-sensitive guidelines for the practical implementation of new strategic plans on adolescent sexual and reproductive health, family planning, gender-based violence, maternal and newborn health, and HIV and sexually transmitted infections at both national and district levels, ahead of the development and execution of district development strategies.		RBC - MCCH Division, Director of Health Facility Programs Unit (Dr Francois Regis CYIZA) and Alight programme coordinator (Chantal Uwambaza
Provide technical and financial support to all public and private midwifery schools to effectively implement a standardized competency-based midwifery curriculum and augment the number of master trainers in emergency obstetric care.		Midwifery School (Tengera Olive), Rwanda Association of Midwives (RAM), President, Josephine Murekezi
Advocate for the establishment and implementation of sustainable funding mechanisms, including a gradual increase in resources allocated to the strategic plans for adolescent sexual and reproductive health, family planning, emergency obstetric care, and maternal and newborn health.		RBC - MCCH Division, Director of Health Facility Programs Unit (Dr Francois Regis CYIZA) and UNFPA SRH Unit Lead (Marie Claire Iryanyawera),
Output 2: National and subnational institutions have enhanced capacities to effectively deliver integrated, youth-friendly SRH services, including to key populations and in humanitarian situations. Programme activities encompassed:		
Enhancing the skills of the Medical Procurement and Production Division, as well as selected district health facilities and pharmacies, in various aspects such as supply chain management, data quality control, and the estimation of quantities for sexual reproductive health commodities.		RBC - MCCH Division, Director of Health Facility Programs Unit (Dr Francois Regis CYIZA)
Expanding the number of healthcare facilities providing high-quality services that are friendly to youth and address issues related to gender-based violence, while also promoting gender equality across different humanitarian sectors.		UNFPA SRH Unit Lead (Marie Claire Iryanyawera), Alight programme coordinator (Chantal Uwambaza
Supporting the implementation of HIV prevention and a comprehensive condom program, particularly targeting female sex workers, in accordance with the UNAIDS division of responsibilities.		RBC - MCCH Division, Director of Health Facility Programs Unit (Dr Francois Regis CYIZA)

Ensuring readiness for emergencies and a swift response by prepositioning essential reproductive health kits that can save lives.		RBC - MCCH Division, Director of Health Facility Programs Unit (Dr Francois Regis CYIZA)
Enhancing the quality of midwifery training, both before and during service, through mentorship, the expansion of mobile learning systems, simulation exercises, and the provision of teaching and learning materials.		Midwifery School (Tengera Olive),
Young people, especially young girls, are equipped with knowledge and skills to make informed decisions on reproductive health and reproductive rights and to fully participate in development and humanitarian actions.		FGD Adolescent Mothers from Kiziba and Mahama camps, FGD adolescent mothers Rubengera, and FGD Peer Educators Rubengera, Health Development Initiative, Research Director (Louange Twahirwa), and Alight programme coordinator (Chantal Uwambaza).
The unmet need for family planning decreased from 19% to 14% as a result of the contribution of different UNFPA supported interventions including capacity development and support for the provision of quality family planning services and availability of products. UNFPA supported the development and implementation of FP/ASRH Strategy, a guiding document on strategic directions towards FP and adolescents to improve their well-being, demand creation of ASRH services through peer education, targeted ASRH outreaches, mainstream media, social media, digital platforms among others which have increased knowledge, demand and linkage to available ASRH services.		FGDs from Adolescent mothers of Mahama camp.
Assumptions for verification 2.2: ***Implementation of the activities has led to increased utilization of integrated SRH services***	**Indicators:**	**Methods and tools for data collection:**
	I.1: Number of the SRH services introduced due to the 8th CP	● Document **reviews**
	I.2: Changes in the geographic coverage of SRH services due to the 8th CP	● **Interviews with UNFPA CO staff, National Stakeholders, Implementation Partners**
	1.3 Evidence of greater availability and use of SRH service by most vulnerable groups	● **Site visits and observations**
	1.4 Changes in the geographic coverage of SRH education for young people due to the 8th CP	**Interviews with UNFPA CO staff, National Stakeholders, Implementation Partners**
	1.5 Assessment of the quality of available SRH services	**Interviews with UNFPA CO staff, National Stakeholders, Implementation**

		Partners
The capacity of 60 healthcare facilities has been enhanced to deliver services that are friendly and accommodating to key populations, aligning with the recommendations from the study on HIV intervention adoption among key populations. Out of the 61 health centres in the three target districts supported by UNFPA, 27 of them, which accounts for 44%, meet the recommended national standards for providing youth-friendly services. However, this outcome falls short of the intended target due to inadequate designated funding.		UNFPA SRH Unit Lead
Based on the 2022 Service Delivery Point (SDP) Survey, every primary service delivery point (100%) provided a minimum of three modern family planning methods in accordance with national protocols, guidelines, and regulations. Additionally, 98.8% of them offered a minimum of five modern family planning methods. The trend in the occurrence of no stock-outs for any modern contraceptive on the day of the survey, excluding female condoms and private facilities, exhibited an upward trajectory, rising from 47% in 2018 to 66% in 2020 and further to 76% in 2022.		Service Delivery Point (SDP) Survey 2022
Outcomes: By 2023, people in Rwanda, particularly the most vulnerable, enjoy increased and equitable access to high-quality education, health, nutrition and WASH services. Outcome indicators: Contraceptive prevalence rate. Baseline: 47.5; Target: 57, Adolescent pregnancy rate (15–19 years). Baseline: 7.3; Target: 6		**2022 Annual Report – Rwanda**
The utilization of modern contraceptives in humanitarian settings in Rwanda has experienced a slight uptick, moving from 30.1% in 2018 to 34.96% by October 2022. A total of 1,113 service providers underwent training in various aspects of Adolescent Sexual and Reproductive Health (ASRH), leading to a notable enhancement in the quality of healthcare services provided. A concrete illustration of this improvement can be seen in Mahama, where the implementation of the Kuja Kuja system resulted in customer satisfaction ratings surging from 46.3% in 2018 to over 80% as of November 2022.		**2022 Annual Report – Rwanda**
UNFPA facilitated the feasibility of delivering equipment and supplies to remote areas, developed policies and guidelines based on evidence, expanded interventions across 18 second-generation health posts to enhance service accessibility, and bolstered the surveillance and response system for maternal, perinatal, and child mortality.		UNFPA SRH Unit Lead
UNFPA played a key role in assisting with the creation and execution of the Family Planning and Adolescent Sexual and Reproductive Health (FP/ASRH) Strategy. This guiding document outlines strategic directions for both family planning and adolescent health, aimed at enhancing the well-being of adolescents. UNFPA also supported efforts to generate demand for ASRH services through various means, including peer education, targeted outreach programs, mainstream media, social media, and digital platforms		UNFPA SRH Unit Lead, Alight programme coordinator RBC - MCCH Division, Director of Health Facility Programs Unit
The UNFPA initiatives have resulted in increased awareness, demand, and utilization of available ASRH services. As a result, there has been a reduction in adolescent pregnancies, dropping from 7.5% in 2014–2015 to 5.5% in 2019–2020.		**2022 Annual Report – Rwanda**

Mahama and Kiziba are engaged in activities related to adolescent SRH services.		FGDs from Adolescent mothers from Mahama and Kiziba camps
Assumptions for verification 2.3: *Gender and human rights-based approaches were explicitly integrated into the 8th CP*	**Indicators:**	**Methods and tools for data collection:**
	I.1: Evidence of systematic gender analysis to inform the design of the 8th CP	**● Document review**
	I.2: Evidence of capacity development om gender integration into 8th CP programming	**● In-depth-interviews**
	1.3 Evidence of human rights-based approaches applied in programming for 8th CP	**● Key informant interviews with CO staff and IPs**
	1.4 Evidence of positive changes in the area of gender equality due to the 8th CP interventions	**● Key informant interviews with CO staff and IPs**
UNFPA's 8th Cycle of Country Programme (2018–2023) was founded on a thorough comprehension of Rwanda's unique dynamics, requirements, and focal areas. It considered the existing policy frameworks, national and global development strategies, as well as sector-specific evaluations related to sexual and reproductive health, adolescent and youth development, gender equality, women's empowerment, and population and development.		**Interviews with UNFPA CO staff,**
The 8th Country Programme (CP) successfully increased awareness regarding gender-related matters and harmful traditional customs within the nation. It also highlighted the importance of integrating gender considerations into national plans. The assistance provided for advocacy and awareness efforts effectively enhanced understanding of gender inequality and gender-based violence (GBV) issues.		Interviews with UNFPA CO staff**,** Alight programme coordinator
Programme interventions include: (a) building the capacity of the Medical Procurement and Production Division, selected district health facilities and pharmacies in supply chain, data quality management, forecasting and quantification of sexual reproductive health commodities; (b) scaling up the number of health facilities providing high-quality youth-friendly and gender-based violence services and promoting gender equality across humanitarian sectors; (c) supporting the implementation of HIV prevention and comprehensive condom programme targeting female sex workers as per the UNAIDS division of labour; (d) ensuring emergency preparedness and a timely response through prepositioning of lifesaving reproductive health kits; and (e) improving the quality of pre-service and in-service midwifery training through mentorship, scaling up of the mobile learning system, simulations and the provision of teaching and learning materials.		
ADOLESCENTS AND YOUTH		

Assumptions for verification 2.1: Planned outputs were achieved and contributed to outcome results in SRHR, AY and PD	**Indicators:** **I.1: Evidence of achievement of CP output targets** **I.2: Utilization of the outputs of the 8th CP to contribute to outcomes results**	**Methods and tools for data collection:** Documents review Interviews with Key informant, UNFPA CO staff, Implementation partners, Focus group discussions with beneficiaries Visits to Intervention sites at districts.
Data collected		***Source of information***
Twenty (20) youth facilities strengthened and equipped, and people trained		KII with CO
Functioning youth corners established (two in Shagasha and Bugarama)		KII with Local lead
We have youth corner ⇔ a friendly space where the youth have the needed services such as responding to questions about sexuality which was taboo, and the problems caused by parents on the basis of the cultural norms are avoided		IDI with IPs
Functioning youth corners and providing many services: Counselling, advice, information on SRH, Family planning, circumcision, testing STI,		FGD with IPs
Equipped and functioning youth corners at health centres		IDI with IPs KII with Local lead
Functioning youth corner which is equipped with: tv screen (for SRH messages, tv, film/movies, sketches on SGBV), room for meeting/discussion/workshops, room for advice and counselling (post exposure prevention and other advice), traditional dance for students during holidays, and condom distribution ⇔ Frequency of the youth corner: 3 times per week when students are in holidays, and once a week in other days.		FGD with IPs
Condoms are being distributed at hospital and youth corners Functioning youth centres/Yego Centre		KII with Local lead
Combination of SRH with other interventions (Economic empowerment and counselling)		IDI with IPs
Adolescent mothers economic support: Mushrooms + soap making + motorcycle to transport to the market + driving skills training (3 people) domestic animals, start-up cash, …..		FGD with IPs
"We support adolescent mothers to support themselves" Intervention was coupled with economic and survival support [income generating activities]: start up package for small businesses, distribution of domestic animals, tailoring/sewing, mushroom production, soap making, we bought motor to transport their production to the market, formation of saving groups and associations, etc. (all group members have received such other supports: goats, pigs, 80,000RWF as start-up…). (given to adolescent mothers)		FGD with IPs KII with Local lead IDI with IPs
Vocational training/tailoring, training in financial management,		FGD with IPs; IDI with IPs

180 youth supported in vocational training [Swiss TPH] 290 children returned to school [Swiss TPH]	KII with Local lead
Bistro/café/bar/restaurant for the youth supported => this was stopped when the initiators were relocate to other countries Adolescent mothers trained and assisted in the camp: advice as new mothers, how to prepare nutritious/complete meal, provided porridge (flour), counselling, intergenerational dialogue, training in family planning Abashangazi (mothers' group established to give advice to the youth in all that has to do with behaviours, sex and sexuality from cultural perspective)	FGD with IPs
Socio-economic capacities strengthened for 1st birth adolescent mothers; adolescent livelihood capacities sustained. Youth's capacity network strengthened in order to participate in programme design	KII with CO
Psychosocial counselling services at youth centres	KII with Local lead
Health staff doing well in helping the youth. They are very empathetic and helpful	FGD with IPs; KII with Local lead
Community capacity strengthened through training: health workers, religious leaders We have finished defining our strategies which help us to select partners and mapping youth's organisations Youth organisations and youth leadership are strengthened through training in SRHR Innovation accelerator programme is increasing knowledge and skills in SRHR => IA Entertainments organised in schools around SRH have promoted the awareness of SRH A lot of dialogues were organised to discuss SRH with the youth and religious leaders at lower level	IDI with IPs
Peer educators are trained and are training/informing other youth in the community/camp on SRH, drug addiction, SGBV, STI, HIV, pregnancy (10–24 years old young people), …. Peer educators are spreading awareness campaign in the camp (Kiziba): SRH, condom use, hepatitis, adolescent pregnancy/unwanted pregnancy, fighting drugs, HIV/STI, birth interval, post exposure prevention, counselling and support… They refer also the youth to health centre in the camp	FGD with IPs
Capacity building of community members organised at all levels of the district in SRH Formal and informal means (formal: trained nurses, youth corners training) (informal: Radio broadcast, speeches during the events) are being used to spread information on SRH	KII with Local lead
Peer educators work closely with (refer the youth to) health centre staff on the matters of adolescent pregnancies and SRH	FGD with IPs
Messages about SRH is everywhere; Selected ambassadors (educators) were trained and now are doing the job	KII with Local lead
We train adolescent mothers about SRH, life skills, good relationships Tools (sermon and messages) rooted in the holy scriptures (Quran, Bible) on SRH (and maternal health) among the youth were developed and used	IDI with IPs

Using mobile phone to help the youth access SRH information Still working on issues of innovation in order to improve our services Using holy scriptures (Bible, Quran) to teach/promote SRH among the youth	IDI with IPs
School teachers were trained in CSE =>CSE	KII with CO
Since the intervention of Imbuto Foundation among the adolescent mothers, no second child was observed among the beneficiaries	KII with Local lead
Adolescent mothers supported by AHA did not have second children they are applying Family Planning (FP). Advice and decision on family planning has changed the behaviours of adolescent mothers: those who were assisted do not have second child because they have applied FP principles. "All of us have opted for PF when our children were still small. We now know to care for our kids and have decided not to get pregnant again". Post exposure protection is used as well. Only one girl among the group had two children but this is because she is new comer who got those babies in Nyamagabe camp, not in Mahama where UNFPA/ALIGHT is intervening Non-school adolescent mothers are supported economically to be able to feed their children	FGD with IPs
Rate of family planning in Nyamasheke is 59% (64% at national level); Adolescent pregnancy in Nyamasheke is 2.2% (5.2% at national level)	KII with Local lead
Change of behaviours among adolescent mothers: reduction of adolescent pregnancies. Some of them were supported by their parents (and UNFPA through intergenerational dialogue) to return to school.	KII with CO
Information about SRH and HIV is widely discussed in the camp, even informally (by friends and neighbours) among the refugees.	FGD with IPs
Adolescent mothers are able to support their families and there are a lot of testimonies in e.g. in Mahama Camp, they are no longer depending, but producing Our beneficiaries can now deliver SRH message to the community, the message they got through peer educators Youth are now very committed to attend the meeting on SRH and adolescent pregnancy (their numbers keep on increasing) The understanding of SRH had changed/increased, our beneficiaries (the youth) can now make informed decision There is increased awareness: among the 12 schools and 20 thousand students who attended our sessions they now dare talk about SRH with less shyness, especially about menstruation and its management. Students changed the way of managing menstruation with more hygienic practices (we supplied them with pads). They are convinced that menstruation is not disease The community was highly interested in our programme to the point that the requests went beyond our plan/intended beneficiaries. Currently religious leaders are aware that they have role to play in the promotion of SRH among the youth and	IDI with IPs

are engaged to participate, as part of their spiritual mission. SRH is no longer a taboo or viewed negatively. Religious school leaders testify that students' awareness about SRH has increased due to dialogues organised by religious leaders Religious leaders and members are now aware of what is happening outside and know what to do in the area of SRH. They talk and discuss about it while this was not the case before UNFPA programme.	
Awareness of the Adolescents and youth about SRH has increased, their mind on SRH and pregnancy has changed	IDI with IPs; FGD with IPs
The cases of pregnancies were increasing and it was hard to control them in the camp since people live together, but with the intervention of AHA, they started stopping because family planning service is working ⇔ adolescent mothers supported by AHA did not have second children they are applying FP "We were shy and could not stand before the people in the meeting to speak, but now we can and we do" "We reach out even out of the camp to attend meetings organised by UNFPA at national level in Kigali" Drug addiction has changed. Boys are no longer stealing money or survival allowances (food distributed in the camp) from their parents to sell them for drug or alcohol (which was one of the factors of having unplanned sexual intercourse)	FGD with IPs
Non-educated girls are now informed of SRH, their former wrong understanding was challenged, now they understand. The former (wrong knowledge included: Body's spots in girls' face are healed by sexual intercourse flesh to flesh (without condom) or by rubbing them with man's sperms No pregnancy during menstruation period; when sexual intercourse happens within water; when sexual intercourse happens in standing position (when they are not laying on bed); when you dance just after sexual intercourse or when you bath just after having sexual intercourse (because sperms come out and fall down) Slim woman gets good shape with big thighs by having sexual intercourse Unceasing menstruation is healed by doing sexual intercourse Pregnancy is prevented by taking pills everyday Violence committed by same age boy is not considered as violence (he is not arrested, no need to report him)	FGD with IPs
Comprehensive sexual education (CSE) is focusing on schools while adolescents and youth out of school need this knowledge and skills as well	IDI with IPs
A lot is still yet to be done in order to reach a huge number of those who were not reached, a lot of unawareness in the community [Icyuho to reach the population]. People (all genders and all categories) still do not have the information about when and how to get pregnant For example girls and women may be pregnant but they don't know and cannot trace when this has happened. A boy may impregnate a girl/woman but at the time of sexual intercourse, he does not know whether there is possibility of impregnating her.	IDI with IPs KII with Local lead

Because AHA has stopped its intervention in the camp, services are few and slow: transfer of mothers to health centres/hospitals are too slow, perinatal deaths have increased ⇔ AHA is no longer there to provide peer educators with material allowances (umbrella, waterproof jacket, soap, tooth paste… Currently there are many problem with (teen) mothers after the birth of the child The child's father abandons the (teen) mother and frustrates her "You are not beautiful, if I knew you will look like this I would not have slept with you". Small youth corner: the youth centre is very small compared to the size/number of the youth in the camp: a house with four rooms, one of which being used as multipurpose/video room, and three serving as offices and counselling rooms. There is a problem of discretion of the youth who seek advice in SRH at health centre: Youth corner is safer than health centre [currently managed by Save the Children] in Mahama camp in terms of discretion because at youth centre none knows what you come to do since there are a number of activities then the youth use this opportunity to seek advice on SRH. But at health centre the youth are in risk of meeting their parents there and would start questioning or suspecting them. However the health centre can help as well and distribute condoms and give other advice but with less discretion	FGD with IPs
Not all the needs of beneficiaries were met. For example, in schools we work with some classes but these classes receive the new population each year so the work should continue. In addition, the teachers change often, there is no guarantee that teachers who are familiar with the programme will remain where they were during CP implementation Scarcity of staff in youth corner: Services within youth corners need to be strengthened because there are very few staff to the point that services are not maximum (scarcity and low quality of services and equipment)	IDI with IPs
One site of youth (centre) per sector is very few. It is difficult to reach it. It is far from the people	FGD with IPs
Problem of accessibility: Youth centres are still few. One centre at sector level (and one YEGO centre at district level) are very far from many people.	KII with Local lead
Financial challenge: Limited financial resources (as compared with the needed services) in order to reach every youth. We no longer have UNFPA financial support since June 2023 although the staff that were helping the youth are still working (ALIGHT)	IDI with IPs KII with Local lead IDI with IPs
Adolescents and youth programme has the lowest funds ⇔ there is need to include innovation and new finance system	KII with CO
We do not do what we want to do because of scarcity of funds. We are still depending on others financially Low leadership capacity of youth led organisations	IDI with IPs
SRH awareness among the youth is almost always limited to sex, sexuality, and reproduction rather than including policies as well, so SRH awareness activities should go together with related policies (or government vision and strategies)	KII with Local lead

Lack of basic means to help girls who menstruate when they attend training session in SRH Teenagers who bring their infants during SRH training session do not find a way to take care of them (food/milk, care) or they disturb during the sessions Expensive transport cost during the SRH session (costing more that the compensation provided during SRH training sessions); The few transport compensation ("Water") comes very late when the participants have started complaining against peer educators No demonstration materials e.g. sex (male or female), condom to be used during the training to help peer educators	FGD with IPs
User friendly tools still missing: MIGEPROF was supposed (has promised) to produce them in order to harmonise the message [leaflets, …] Negative solidarity: the girl or her family hides the information but rather negotiate with the boy or his family for private/discrete arrangement	KII with Local lead
Parents do not report perpetrators of sexual violence against their daughters with expectation of private or family arrangement	FGD with IPs
Essential equipment and drugs (lifesaving to mothers against haemorrhage) is still few in general, more financial resources are still needed	IDI with IPs
Women are always in weaker position in matters of sex. They do not negotiate for safety Under 18 yrs old are the most vulnerable and the most concerned by behaviour change programme. They are very needed as tomorrow's nation.	KII with Local lead
Cultural and social norms preventing some teachers and health service providers from properly delivering the message on SRH to the youth	IDI with IPs
There is a problem of culture: Boys and girls are still shy about SRH (speaking, explaining, asking information, sex negotiation...) this prevent also the victims of sexual violence from reporting the perpetrator or if they do, it is the time when evidences are no longer traceable	KII with Local lead
Cultural norms: One adolescent mother was not able to use family planning methods because her sister-in-law threatened her that if she does it she will be openly confirming that she is a prostitute and that she wants to sleep with men then and now. This sister in-law was staff at Kibogora hospital and was in connection with all the services in this hospital as well as in Kibogora health centre where the adolescent mother could go for advice about family planning. This means that any trial she could initiate to use FP would be known to her sister-in-law, which would be an opportunity for family threat and rejection. So she did not use FP methods despite her willingness to do so.	FGD with IPs

There is power imbalance between the youth and other groups. Youth organisations' dreamed innovation is not taken into consideration while projects from senior people and other organisations are privileged [Problem of approval and funding for projects]. The approaches that senior organisations use are costly but not efficient. They are just spending money. They focus just on the implementation with less consideration of the impact of their intervention. E.g. training a given number of people [2 peer educators in each village] (focus on the quantity reached) without looking at the quality of training and the skills given to the trainee. In their training, they only use books and manuals. AfriYAN want to implement, promote the quality, supervise, and follow up, ensure that the needed results and impacts are produced. AfriYAN want to use card as didactic material as well as other efficient materials. We want holistic approach where we consult the community, we monitor and build the capacity. There were natural catastrophes that disturbed the implementation activities for example in Karongi, Gisovu, the roads are affected by floods inundation and all the rainy seasons are problematic (but no meaningful negative effect was observed)	IDI with IPs
Community engagement is key: Community people are able to mentor and transmit knowledge to their fellows Building the capacity of people is very important if we want to see changes Youth can achieve a lot if supported or given opportunity to participate Never underestimate people's issues or supposed to know them better than the concerned people. For example: for adolescent mothers, we need to be with them in order to help them. It is not good to decide on their behalf. Financial support is not an end and is not enough for an effective support. It may support the real intervention	IDI with IPs
Taking every opportunity to spread the message about SRH (E.g. World population day, church service, media…)	KII with Local lead
Continue working on adolescent pregnancy prevention and SRH awareness Organise refresher course for those who followed the training Extend the programme to other who have not yet attended SRH course/increase the number of the adolescent mothers supported by the programme "Be kuducutsa [Imbuto Foundation should not stop working with adolescent mothers]- we heard that they want to move to Nyamasheke and leave us at this level, no we want them to continue with us" [KII with Local lead] We need more economic support for adolescent mothers because those who were supported are still few when compared with those in need	IDI with IPs FGD with IPs KII with Local lead
Organise refresher course on SRH	FGD with IPs
Refugees are still coming in the camp, so AHA and other services should continue and increase, rather than being stopped. Change peer education services into formal paid services where the peer education receive a monthly salary (Inn: Maybe the few allowances provided in materials can be increased and turned into monthly financial allowances for multiple use)	FGD with IPs

Peer educators need the study visits outside their camp in order to learn from others in terms of youth corner functioning and job creation	
Combination of some interventions for a maximum reach of the youth: e.g. economic support to the youth is much attended, so this should be a good opportunity to convey the message on SRH as well rather than separating the youth's invitations (one for SRH and the other for economic activities) Include economic support and vocational training in the package of SRH awareness	IDI with IPs KII with Local lead FGD with IPs
Bring back the medical staff in youth centre in order to help the youth who seek advice Peer educator should be supported/helped to continue their work in SRH awareness at youth corner and in the community Bring back AHA and its services, otherwise Save the Children which is managing the camp currently is not providing services that AHA was providing	FGD with IPs
Go beyond the 3 district: Nyamasheke, Rusizi, and Karongi (Western Province). E.g. Ngoma district in Eastern Province has more pregnancies than districts in Western Province	KII with CO
Combine SRH and youth centre and youth corners with other youth activities such as games, vocational training [especially those from Iwawa],	KII with Local lead
Provide food to those who attend SRH training sessions, most especially those having small children (adolescent mothers), otherwise they spend the whole day empty stomach	FGD with IPs
Economic support should not be limited just to a small amount of money but also advisory services and monitoring their lives' improvement. The supporter should also ensure that the assistance they provided is able to position someone within the field of business because sometimes insufficient amount may cause a waste of time or a failure (e.g. not having a place in the market in order to do small business, not having survival means while rearing the domestic animal…). Having enough amount would help to pay taxes, be stable at market rather than hiding from the police with all the connected risks, keep the client by having a known address. Increase the start-up kit and tool kit (to those following the training and those supported by the programme)	FGD with IPs KII with Local lead
Consider multisectoral approach in addressing the problems of the youth: Include also mental health and other vulnerability in addition to economic support	KII with CO
Youth corners should not remain in health facilities only. They should be taken to school as well (not to be confused with girls' rooms). Youth corners are still needed in other places, especially in Muganza and Nyakabuye sectors where sexuality is very intense among the youth	IDI with IPs KII with Local lead

Make SRH promotion among the youth a family-based intervention [train parents]. This is because parents are requested to contribute to informing the youth but these parents need this awareness like their children and by now they are not yet very open to their children about SRH. They do not have the right or common message to transmit to their children. If parents' awareness is increased, this will equip them and increase their openness, which will help them to be efficient in this action SFH should work with youth centres in organising discussions with the youth and distribute condoms. Adult people should be involved in SRH awareness as well The focus on boys in SRH promotion is needed as well rather than focusing on girls only, because boy have none to inform them. The energy used to inform girls is need to inform the boy (and men in general) as well. They need to know the wrong which is in impregnating a girl and how to contribute to avoiding it. Boys/men need their own training on SRH because they do not know everything. This would help them to continue contributing to reducing unprotected sexual activity	IDI with IPs KII with Local lead
Encourage NGOs which are not intervening in the area of SRH to do so. Train and strengthen them in this matter Youth friendly technology (communication materials) is needed to be used in promoting SRH awareness among the youth Disburse funds for a long period like one year or at least 6 months Partner directly with IP without any intermediary organisation, which will quicken the access to funds (administrative processes within the intermediary organisations delays the implementation and reduces the amount of funds that should be reserved to the intervention itself) Invest more in institutional (IP) strengthening in order to help their capacity (HR, technical training) so that they can uptake the work initiates by the programme Multiply the number and categories of people who are almost permanent with them, to equip them in order to promote SRH awareness among the youth as well as the sustainability of the achievements: e.g. teachers/leaders in schools, local leaders, religious leaders, youth councils, family evening forums, …. In school, SRH is currently taught as part of their course where they simply work for academic marks and not for life skills where every practical need is met, so there is need to properly equip teachers in this regards. Religious leaders have Sunday schools and other youth/children groups and programmes, they are the ones preparing the youth for marriage and blessing their weddings and guide them in their future life of marriage… The involvement of these opinion leaders would increase the sustainability of the achievements of the programme Let us have harmonised way of explaining SRH (same message, same categories of formed groups…) Let's have sex and sexuality a normal thing which is easy to discuss rather than taking it a s taboo. Having erection should not bring shame, people should talk about it.	IDI with IPs
Increase the number of sites of youth and SRH centre (at least at the level of cell) => SRH services should be	KII with Local lead

decentralised => recruit the staff/educators at the decentralised level	FGD with IPs
Increase the number of sites of youth SRH centre (at least at the level of cell) Increase the transport fees ("Water") for peers and monthly fees for peer educators Give peer educators mobile phones and bundles to Facilitate contacts with peers and programme (CP/IP) staff Organise refresher course for peer educators on SRH Be gender sensitive during evaluation (only men were mostly visible during the CP evaluation) Youth centres should not be limited to SRH but include other activities such as games and leisure activities, handcraft, Information technology (IT), music, film, knitting… "I am jealous when I hear from the radio what other young people are doing or benefiting" Increase the size and services in youth corner: a bigger multipurpose room, other rooms for counselling activities, games for children and youth, antidrug occupation activities (activities occupying the youth preventing them from hanging out/wandering/being idle), employment and job creation to those who finished their studies Youth evening forums are needed, similar to family evening forum, Separate boys from girls when talking about sex for discretion purpose. Operationalize group sessions by putting together people of the same category: young boys, young girls, parents… in order to facilitate the openness when they talk during SRH session [this means that adult people should not be excluded because they are not knowledgeable about SRH] ⇔ But other people's opinions are needed as well. Use multiple ways of doing sex awareness Target the parents as well since they also do not have quality information on SRH ⇔ design appropriate tool for them Organise mass mobilisation on SRH using radio, meetings, SRH awareness activities should go together with related policies Increase the number of staff in SRH at health centre, especially recruit the staff who remain at youth centres who can provide services whenever needed Create evening youth forum in every village in order to facilitate the awareness about SRH Expand Isange One Stop Centre in all sectors so that victims of SGBV may easily find where to report	FGD with IPs

We need youth projects that benefit not only the refugees in the camp but also the surrounding community because they are all interacting e.g. in the church, in the market…. Local leaders are also requesting such interventions in their communities Expand the programme beyond the three districts and serve the entire country Expand job creation among the youth in order to keep them busy as a way to fight against drug addiction and unwanted pregnancies Expand the creation of youth centres and equip them. There are many infrastructures that can be used all other the country All the funded NGOs should sit together and share their planning in order to have harmonised work without duplication Increase the funds among the youth (I accelerator especially) Let's allow beneficiaries to co-create, involve them into identifying needed intervention		IDI with IPs
Train peer educators the signs for people with speaking impairment so that they can be able to serve them properly		FGD with IPs
We change message according to the changing of national policies: e.g message for reproductive health was initially for prenatal consultation sessions (antenatal care visits), later the policy changed into 8 visits then the message by church leaders also changed into 8 visits; Alco, the intervention on SRH among the youth has been to involve adolescents and youth into awareness and participation. But the focus on engaging parents came later with reference to national and MoH strategies There was change of intervention strategies during COVID 19: from face to face intervention to mobile clinic although health facilities continued working as well. We had remote management services (management of SGBV cases) during covid period COVID was an obstacle but peer educators played great role during COVID It is during covid that we started with UNFPA programme (2020), we worked much through stakeholders such as churches …. As well as materials like leaflets,		IDI with IPs
Assumptions for verification 2.3: Gender and human rights-based approaches were explicitly integrated into the 8th CP	**Indicators:** **I.1: Evidence of systematic gender analysis to inform the design of the 8th CP** **I.2: Evidence of capacity development on gender integration into 8th CP programming** **1.3 Evidence of human rights-based approaches applied in programming for 8th CP** **1.4 Evidence of positive changes in the area of gender equality due to the 8th CP interventions**	**Methods and tools for data collection:** Document review In-depth-interviews Key informant interviews with CO staff and IPs

Data collected	***Source of information***
For the youth programme, both girls and boys are beneficiaries People (youth) with disabilities supported together with other beneficiaries; People with disabilities, out of school girls, most poor considered during the implementation	KII with CO
Gender is always catered for right from the time of planning as requirement stipulated into NST1, SDGs, Development sector's policies, etc. so it is taken into account at every stage of the programme implementation and monitoring and evaluation as well Gender is mainstreamed everywhere (including mental health and human rights) We supplied girls' rooms at school and they are no longer ashamed by menstruation We avoid stairs wherever we work in order to accommodate people with disabilities Wherever we intervene we select beneficiaries who are the most in needs	IDI with IPs
Adolescent mothers who were initially rejected by their families are now accepted and reintegrated in families& schools as result of the interventions (peer educators' work and other sensitisations such as intergenerational dialogue)	FGD with IPs
Intergenerational dialogue between adolescent mothers and their parents, facilitating family reintegration	KII with Local lead
Attitudes and behaviour change: Parents were trained/sensitised about adolescent pregnancies, they know everything and have now changed their attitudes toward adolescent mothers, "Nanjye narahindutse kubera ubumenyi, navuye mu bigare, turumvikana neza n'ababyeyi banjye kuko nahinduye imyitwarire. Hari n'abandi bakobwa batatu babyaye batumvikanaga n'ababyeyi babo baratandukanye none baragarutse barabakira barabana neza mu nkambi" (I have changed as well, I left groups of people that would deceive me, I agree with my parents on everything because my behaviour has changed. There are three other adolescent mothers who had left their parents but now came back and were received and they live peacefully together). "Another girl was impregnated when she was at school, then parents were angry and aggressive, but she is now accepted in the family, she was even supported and returned to school, leaving her child with her parents" Consulting health centre gives confidence, provides counselling/rest, heals frustration due to the reproach induced by the family (especially when after the HC service and support, there is behaviour change in a way that accepted by the society and parents), gives independence (especially when SRH is mixed with economic support). A adolescent mothers supported by GNI mentioned that when people who used to mock her because of pregnancy, now (after being supported by the project) when they dare to mock her again she says to herself "say whatever you want to say, what I know is that now I am someone, I am a human, I am not an outcast. None can look down on me again. How can they look down on me while I am independent and contribute to their lives? They need me to survive, I buy a soap that everybody can use at home (but before I have that capacity they could not allow me to use their soap). Good Neighbour International has really helped us very	FGD with IPs

much, no basis on which we can blame them." [This adolescent mother was trained and supported by GNI and given a start-up amount of 80,000RWF for her small business. Youth now dare talk about sex, which formerly was taboo Although both boys and girls are involved into SRHR awareness, further economic support to most vulnerable people focuses more on girls and adolescent mothers than boys. Boys with disabilities are viewed by peer educators as in need of economic support as well.	
MINEDUC not duly involved: Ministry of Education (MINEDUC) is not contributing much on CSE in schools, leaving this work to Ministry of Health and NGOs, while they are the ones in a good position to develop and implement this strategy	IDI with IPs

Evaluation Question 3: **To what extent to which the 8th CP outputs and outcomes have been achieved with the appropriate number of resources – funds, expertise, time and administrative costs etc? and used a set of appropriate policies, procedures and tools to pursue the achievement of the outcomes defined in the CP? Were the programme interventions and outputs produced in a cost-and time efficient and quality manner?**		
Evaluation Criteria: [Efficiency]		
SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS		
Assumptions for verification 3.1: ***SRHR implementers received resources as planned to the expected level, on time and in a consistent manner***	**Indicators:**	**Methods and tools for data collection:**
	I.1: Funds were disbursed on time and of expected amount to implementation partners	• **Document reviews**
	I.2: Funding level was adequate to enable IPs undertaken planned activities	• **Interviews with UNFPA CO**
	1.3 Extent of engagement and contribution of the national partners	**Interviews with UNFPA CO staff, National Stakeholders, Implementation Partners**
The funds allocated to implementing partners (IPs) are typically utilized in a responsible manner, strictly for their designated purposes. Delays in fund transfers have a detrimental impact on the execution of planned activities. IPs have frequently encountered situations where they had to expedite activity implementation due to consistent delays in fund disbursement. A protracted process involving the approval of annual plans, review of reports, and the subsequent transfer of funds exists		Health Development Initiative, Research Director (Louange Twahirwa) And Rwanda Association of Midwives (RAM), President, Josephine Murekezi
In Mahama and Kiziba camps refugee camps, comprehensive adolescent SRH services (ASRH) were efficiently offered. Their capability to deliver high-quality services was improved by training healthcare		FGDs adolescent mothers and KIIs from Kiziba Africa Humanitarian Action Field

providers in ASRH, distributing informational materials, engaging with community and religious leaders, and constructing and renovating four dedicated youth spaces to provide adequate infrastructure for adolescent SRH services		staff and ALIGHT Mahama Field staff
The FP2030 Commitments, introduced in April 2022 under the guidance of the Ministry of Health (MoH), have provided an avenue for various stakeholders to collaboratively support the implementation of family planning policies and programs in Rwanda. A significant milestone was reached when the Government of Rwanda (GoR) signed an agreement to allocate and contribute a minimum of 1% of its annual budget to the UNFPA supplies fund for the procurement of family planning commodities. This allocation serves as an extra contribution towards family planning commodities. $945,281 was mobilized in 2022, below targeted $1.2 million. $3 million ($2 million through the Strategic Investment Facility for 4 years and $1 million through additional RR for census) was mobilized in 2022. Census activities were fully funded and the CO contributed close to $2 million this year, from core and earmarked resources from SIDA funds, this positive result. Due to that commitment, the government of Rwanda spent approximately $1,185,110 on quality-assured RH/FP commodities in 2022. This represents an increase of $1,113,009 since 2021 (13%). As a result, the government was granted additional $1,113,009 worth of RH/FP commodities through the Match Fund.		2022 Annual Report – Rwanda
Assumptions for verification 3.2: ***Both UNFPA CO and implementation partners had adequate human resources capacity to implement SRHR resources of the CO and selected approaches were sufficient to adequately implement activities planned for 2018–2024.***	**Indicators:**	**Methods and tools for data collection:**
	I.1: UNFPA CO staffing level matched the competency and workload for SRH, ASRH interventions	● **Document review**
	I.2: Mechanisms were put in place to addressing emerging capacity gaps	● **Key informant interviews with CO staff**
	1.3 Extent to which PPM was used to deliver the 8th CP.	● **Interviews with UNFPA CO**
	1.4 IP HR capacities matched the competencies and number required to deliver 8th CP interventions.	**Interviews with UNFPA CO staff, National Stakeholders, Implementation Partners**
	1.5 Evidence of the timely implementation of the project activities within direct control of UNFPA CO	**Interviews with UNFPA CO staff, National Stakeholders, Implementation Partners**
There was a mandatory regular training on sexual exploitation and abuse and sexual harassment for UNFPA staff and Implementing Partners conducted. And capacity building on management of high-risk pregnancies to		2023 Annual Planning - Rwanda,Alight programme coordinator (Chantal

improve service providers' skills and competencies in managing emergencies to reduce maternal, newborn morbidity and mortality. The main contributing factors of stock-out are the low and no demand, lack of qualified staff to provide the method and the high demand of products (female condoms, male sterilization and Implanon NXT, respectively). Strategies to overcome those gaps include increased demand for all the methods, continuous capacity building of medical doctors on the provision of quality FP permanent methods and advocacy through global partnership to have more than one source of Implanon NXT		Uwambaza, Health Development Initiative, Research Director (Louange Twahirwa), Rwanda Association of Midwives (RAM), President, Josephine Murekezi
Country has a functioning inter-agency coordination mechanism or platform to address sexual and reproductive health and reproductive rights. Country has produced during the reporting year new collective outcomes between humanitarian, development and peace actors at the national level address (a) sexual and reproductive health; (b) reproductive rights. The UNFPA country programme addresses the needs and rights of indigenous peoples. Resources (both human and time resources) were limited to further advocate for a robust M&E system at the IPs; unless separate sessions were organized, the heavy workload did not allow sufficient space for staff to reflect and discuss the robust M&E systems and RBM practices.		2023 Annual Planning - Rwanda,Health Development Initiative, Research Director (Louange Twahirwa) And Rwanda Association of Midwives (RAM), President, Josephine Murekezi
Trainings of health care providers supported to improve quality delivery of SRH services and disability inclusion for adolescents, youth and women, and reports available. UNFPA supports the delivery of girl-centred programmes in the country that build their life skills, health, social and economic assets. Planning and allocation of funds to Implementing Partners were not completed on time as not all committed funds were reflected in the official programming funds available in a timely manner.		Health Development Initiative, Research Director (Louange Twahirwa) And Rwanda Association of Midwives (RAM), President, Josephine Murekezi
Assumptions for verification 3.3: UNFPA policies, procedures and tools contributed to achievement of CP results	**Indicators:**	**Methods and tools for data collection:**
	I.1: Types of policies, procedures and tools established by UNFPA	• **Document review**
	I.2: Extent to which these policies, procedures and tools were used and to what effect	• **Interviews with UNFPA CO staff**
The **UNFPA** provided technical assistance for the revision of the Community Health Workers (CHWs) policy, the strategic plan, and Ministerial instructions. Additionally, they facilitated the dissemination of the CHWs investment case, all of which played a role in guiding the implementation of the updated CHWs versatile model.		KII with UNFPA SRH Unit Lead
In November and December 2022, a total of 377 trainers and 2,188 CHWs underwent training on 14 distinct competencies. These modules encompassed areas such as Maternal Newborn Health, Integrated Community Case Management (ICCM), Nutrition, Community-Based Family Planning (CBP/FP), Mental Health, Non-Communicable Diseases (NCDs), First Aid, Drug Management, Tuberculosis, Malaria, HIV, Behaviour Change Communication (BCC), Emergency Response to Epidemics, Reporting on Community Health Activities, and cross-cutting topics like Early Childhood Development (ECD), Adolescent Sexual and Reproductive Health (ASRH), Water, Sanitation, and Hygiene (WASH), Gender-Based Violence (GBV), and		**2022 Annual Report - Rwanda**

Disability Inclusion. This comprehensive training ensures that all CHWs are equipped to handle a wide range of tasks and offer integrated services, including Maternal, Child, and Community Health (MCCH) services, close to the end users, while also reducing the workload of healthcare providers at healthcare facilities.		
Comprehensive Abortion Care Guidelines were revised and finalized; and the policy, strategic plan and investment case on Community Health Workers were finalized, all are under signature process by the MoH. Disability inclusive education materials for FP were also developed such as brochures, flip charts, videos among others.		UNFPA SRH Unit Lead (Marie Claire Iryanyawera), RBC - MCCH Division, Director of Health Facility Programs Unit (Dr Francois Regis CYIZA)
ADOLESCENTS AND YOUTH		
Assumptions for verification 3.1: ASRH received financial resources as planned, to expected level, on time and in a consistent manner	**Indicators:** **I.1: Funds were disbursed on time and of expected amount to implementation partners** **I.2: Funding level was adequate to enable IPs undertaken planned activities** **1.3 Extent of engagement and contribution of the national partners** **1.4 Extent of the implementation of the recommendations of the Mid-Term review**	**Methods and tools for data collection:** Document reviews Interviews with UNFPA CO
Data collected		***Source of information***
Adolescent mothers supported by GNI financially still need support. The amount of money received do not allow them to have a stand/table place in the market where they can spread their merchandise. They are obliged to work informally so that they cannot pay taxes, otherwise the investment would not be enough. This informal business make these women very vulnerable to attack of local security service who would prevent them from working/trading informally and most of time size their merchandises. This is the same for those who received the domestic animals whose production is very slow and cannot help for emergent matter. One adolescent mother who got a support of domestic animal uttered “the fact that I am still in my parents’ house is making me uncomfortable. There is time all my siblings gather together and mock me, threaten me, and insult me” (this adolescent mother was rejected by the family after being pregnant. She was not allowed to use any utensils in the household, could not use a jerrycan (plastic container) to draw water or a plate to feed her child or a pot to cook for the child. When the parents gave inheritance, she was not given anything. Unfortunately her parents and her child all passed away, she is staying at home which was given to her bother as inheritance. Now whatever happen in that house she is insulted. If a tree falls down she is accused of carelessness and threatened of being fired. She is not able to leave that house because she does not have where to go or any means to		IDI with IPs

support herself. She received a pig from GNI but this animal is yet to produce and to support her financially, she is still in the dilemma whether she can leave this household or not because she has no life there). "Because the project ended" (ALIGHT project in the camp), peer educators are no longer systematically working. They are just working informally as volunteers at lower extent. Even the medical staffs in the youth corner are no longer there, help/advice and other services to the youth has stopped, pregnancies possibly increasing. The youth are afraid to look for help in the health centre because they fear to meet adult people or their parents there, who would start blaming or suspecting them. Peer educators no longer have ALIGHT uniform that was helping them to be identified as peer educator, thus it is hard for a male peer educator to take the youth in another close refugee camp (Mahama 2 managed by Save The Children at 6km) because they are not recognised or trusted as peer educators but rather suspected of being responsible of the girl's pregnancy		
The cost of the programme was less than planned. This was because the GNI staff residing in the operational area but were not initially appointed to UNFPA programme were intervening often		IDI with IPs
Disbursement of money: the money is released for 3 months only, and another 3 month fund is released after the approval of the report of the 3 previous months, which is delaying and disturbing the work, especially due to the time that administrative processes takes (bureaucracy)		IDI with IPs
Poverty play great role in adolescent pregnancy, girls pursuing small gifts Buying condom is another challenge not only regarding the culture (because of shyness) but also regarding poverty (youth do not have money but have girls beside them).		KII with Local lead
Awareness intervention coupled with outreach services give tremendous achievements in SRH services (e.g. family planning …). Campaign within adolescents and youth coupled with services. Involving community health care providers (training them and giving them the whole capacity building package) is very helpful Districts have to be involved, otherwise there will be failure		IDI with IPs
Multisectoral approach (SRH, games, economic, health…) is very successful when addressing adolescent and youth problems. Even the small amount for transport is used by many as start-up or top-up in business Intergeneration (adolescent mothers and their parents) dialogues are also very efficient		KII with CO
Though school teachers were trained in CSE, no follow up/monitoring		KII with CO
Assumptions for verification 3.2: ***Both UNFPA CO and implementation partners had adequate human resources capacity to implement SRHR and AY and PD interventions; resources of the CO and selected approaches were sufficient to***	**Indicators:** **I.1: UNFPA CO staffing level matched the competency and workload for SRH, ASRH and PD interventions** **I.2: Mechanisms were put in place to addressing emerging capacity gaps** **1.3 Extent to which PPM was used to deliver the 8th CP.** **1.4 IP HR capacities matched the competencies and number**	**Methods and tools for data collection:** Document review Key informant interviews with CO staff

adequately implement activities planned for 2018–2024	**required to deliver 8th CP interventions.** **1.5 Evidence of the timely implementation of the project activities within direct control of UNFPA CO**	
Data collected		***Source of information***
Assumptions for verification 3.3: UNFPA Policies, procedures and tools contributed to achievement of CP results	**Indicators:** 3.3.1 Types of policies, procedures and tools established by UNFPA 3.3.2 Extent to which these policies, procedures and tools were used and to what effect	**Methods and tools for data collection:** Document review Interviews with UNFPA CO staff
Data collected		***Source of information***
"As a result of intensified advocacy led by UNFPA and civil society organizations, and policy dialogue to remove barriers for youth and adolescents in accessing SRH-services, the GoR adopted legislative reform that addresses barriers in existing laws by enabling adolescents to access SRH services without parental consent and improving access to abortion services for minors." "AS result of continuous advocacy and policy dialogue for increased access to RH services for youth and adolescents, the Parliament is in the process of updating the Reproductive Health Law to grant adolescents access to SRH services without requiring parental consent."		Document review
"UNFPA contributed to evidence-based policy and decision making through its support to the design and conduct of various surveys and preparatory activities for the 2022 Census."		

Evaluation Question 4: **To what extent to which the benefits of the 8th CP interventions after its termination, linked in particular to their continued resilience to risks? To what extent has UNFPA been able to support implementing partners and rights-holders' beneficiaries (women, adolescents and youth) in developing capacities and establishing mechanisms to ensure the durability of effects?**		
Evaluation Criteria: [*Sustainability*]		
SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS		
Assumptions for verification 4.1: ***Implementation Partners and beneficiaries capacities build with support of 8th CP***	**Indicators:**	**Methods and tools for data collection:**
	I.1: Evidence of capacity build among IPs	**●Document review**

contribute to sustainability of CP benefits	**and beneficiaries**	
	I.2: Extent to which capacities developed will ensure durable effects	**Interviews with UNFPA CO staff, National Stakeholders, Implementation Partners**
Rwanda Family Planning/Adolescent Sexual Reproductive Health Strategic Plan (2018- 2024) is consistent with existing national policies and strategies, and proposes that health care services should be people-centred, integrated, and sustainable in line with the fourth Health Sector Strategic Plan		
The following are the capacity building initiated by UNFPA:		
Improved capacity in youth-friendly service delivery, including for HIV testing and counselling, and for services for care and treatment of HIV/AIDS and other sexually transmitted infections (STIs		RBC - MCCH Division, Director of Health Facility Programs Unit
Carried out initiatives aimed at altering behaviour within the young generation, particularly targeting the overcoming of religious and cultural obstacles that hinder the acceptance of sexual and reproductive health (SRH) services, including family planning services. Enhanced the competency of healthcare providers at every level to ensure the delivery of high-quality family planning and adolescent SRH services (FP/ASRH).		Health Development Initiative, Research Director, Rusizi Vice Mayor Social Affairs, Vice Mayor Economic Nyamasheke
Ensured the strategic placement of family planning-trained healthcare professionals within all healthcare facilities, with clearly defined roles as focal points for family planning and adolescent sexual and reproductive health. This guaranteed comprehensive coverage for the youth.		Health Development Initiative, Research Director ; RBC - MCCH Division, Director of Health Facility Programs Unit, UNFPA SRH Unit Lead
At youth corners, UNFPA partners arranged adolescent sexual and reproductive health (ASRH) initiatives that encompass more than just imparting information and raising awareness; they should also encompass the delivery of comprehensive ASRH services		**Rubengera, Kanjongo, Mahama, Kiziba Adolescent mothers' FGDs**
Extensive participation of school administrators has been demonstrated to enhance the effectiveness and calibre of school health curriculum (SHC) education. Schools in which head teachers have actively engaged in training mentors for SHC have experienced improved administrative backing for the finalization of official SHC reports. This has also encouraged the inclusion of additional teachers in facilitating activities for students within the school. Moving forward, prioritizing the training of head teachers remains essential to boost performance, foster a sense of ownership, and ensure the sustainability of these efforts.		Health Development Initiative, Research Director
Approaches to address the deficiencies encompass heightened demand for all available contraceptive methods, ongoing training and skill development for medical doctors in delivering high-quality permanent family planning methods, and advocating for global partnerships to diversify the sources of Implanon NXT.		Health Development Initiative, Research Director And Rwanda Association of Midwives (RAM), Midwifery School

Capacity strengthening of 5,953 teachers from 18 districts for effective CSE delivery in school		**2022 Annual Report - Rwanda**
3,115 schools equipped with CSE reference books		2022 Annual Report - Rwanda
807 school health clubs provided SRH/GBV information		2022 Annual Report - Rwanda
Capacity building of 97 AfriYAN members on ASRH advocacy issues including ASRH, social accountability		2022 Annual Report - Rwanda
AfriYAN's Strategic Plan, Gender Policy and Procurement policy developed for increased organizational capacity		2022 Annual Report - Rwanda
Capacity building on management of high-risk pregnancies to improve service providers' skills and competencies in managing emergencies to reduce maternal, newborn morbidity and mortality		Health Development Initiative, Research Director (Louange Twahirwa) And Rwanda Association of Midwives (RAM), President, Josephine Murekezi, Midwifery School (Tengera Olive)
Challenge		
Ensuring the continuity of youth services in refugee camps presents challenges, primarily because the entire system relies on the efforts of peer educators and their monthly incentives. It becomes challenging to envision the continuation of activities without these incentives. Moreover, as the young population keeps growing, there remains a crucial need for guidance and education.		**FGDs from Mahama and Kiziba peer educators.**
Assumptions for verification 4.2: ***Types of mechanisms put in place by 8th CP to ensure durable effects of the CP.***	**Indicators:**	**Methods and tools for data collection:**
	I.1: Evidence of mechanisms established by the 8th CP (policies, strategies, infrastructure, networks etc)	**Interviews with UNFPA CO staff** **Document reviews**
Mahama and Kiziba refugee camps successfully delivered comprehensive adolescent SRH services (ASRH). Their ability to provide high-quality services was improved by training healthcare providers in ASRH, distributing informative materials, involving community and religious leaders, and constructing or renovating four youth-friendly spaces to provide sufficient infrastructure for adolescent SRH services		FGDs adolescent mothers and KIIs from Kiziba Africa Humanitarian Action Field staff and ALIGHT Mahama Field staff
Reproductive Maternal, Newborn, Child and Adolescent Health (RMNCAH) policies and guidelines were reviewed and revised.		Health Development Initiative, Research Director (Louange Twahirwa
28 Health Posts supported through innovative financing.		RBC - MCCH Division, Director of Health Facility Programs Unit (Dr Francois Regis CYIZA).
Capacity of Health Care Providers (HCPs) for quality Sexual and Reproductive Health service delivery strengthened.		Health Development Initiative, Research Director (Louange Twahirwa) And Rwanda Association of Midwives

		(RAM), President, Josephine Murekezi, Midwifery School (Tengera Olive)
Assumptions for verification 4.3: There are activities initiated by the UNFPA that were continued and scaled up by government	**Indicators:**	**Methods and tools for data collection:**
	I.1: Information about activities initiated by the UNFPA that were continued and scaled up due to partnerships with government and other United Nations entities	● **Document reviews**
The continued partnership between UNFPA and the School of Nursing and Midwifery in the University of Rwanda and other stakeholders collectively strengthened the capacity of the midwifery department.		Midwifery School (Tengera Olive) and Rwanda Association of Midwives (RAM), President, Josephine Murekezi,
The UNFPA partners agreed to scale up the newly developed e-learning programme along with the training on the polyvalent model to allow CHWs' self-learning. Profile of 19 iAccelerator solutions documented; mentorship for scale up implemented. The partnership between UNFPA Rwanda and KOICA has been nurtured since 2017 with collaboration and joint effort around sexual reproductive health issues and further strengthened in May 2019 through the scaling-up of the YouthConnekt initiative in Rwanda that extended financial support to UNFPA's Innovation Accelerator programme. In July 2020, a new grant agreement was signed between the parties and marked the beginning of a three years' multilateral project which will support Rwanda in fulfilling its ICPD25 commitments.		2022 Annual Report - Rwanda
UNFPA receives contributions from various United Nations agencies, particularly in support of three collaborative programs: (i) Assisting in the development of education and health services for communities, families, vulnerable adolescents, and youth, (ii) Enhancing the capacity of national and sub-national institutions to collect data and improve evidence-based policy planning, analysis, and monitoring and evaluation, and (iii) Reinforcing human security by increasing resilience to natural disasters and climate-related hazards in Ngororero District.		2022 Annual Report - Rwanda
The UNFPA Rwanda and KOICA partnership was established in 2017, primarily focused on sexual reproductive health matters. This collaboration was reinforced in May 2019 when they expanded their efforts by supporting the YouthConnekt initiative in Rwanda, which included financial backing for UNFPA's Innovation Accelerator programme. Subsequently, in July 2020, both parties signed a fresh grant agreement, commencing a three-year multilateral project aimed at assisting Rwanda in fulfilling its ICPD25 commitments.		2022 Annual Report - Rwanda
ADOLESCENTS AND YOUTH		
Assumptions for verification 4.1: ***Implementation Partners and***	**Indicators:** 4.1.1 Evidence of capacity built among IPs and beneficiaries	**Methods and tools for data collection:** Document review

beneficiaries capacities build with support of 8th CP contribute to sustainability of CP benefits	4.1.2 Extent to which capacities developed will ensure durable effects of 8th CP	
Data collected		***Source of information***
Health system is inherently complex to the point that all the intervention system is integrated into the existing system where there is assurance that interventions supported by UNFPA will remain even after the programme has ended, at least technically (financial resources is the only issue). Religious leaders are also trained so that they can be able to manage interventions initiated by the programme Helping the adolescent mothers to return to school and vocational training ensure the sustainability of the intervention Interventions of the programme are owned by religious leaders in their own contexts at all levels. They are also trained so that they can be able to manage them fully and efficiently. SRH is included in the strategic plans of religious institutions We have a guiding document (provided by UNFPA) used in integrating SRH (for Adolescents and youth and adults) in religious institutions' strategic planning Technical training provided to adolescent mothers will continue to be used (in business such as soap making, mushroom production…) By supporting income generating activities, adolescent mothers are being helped to support themselves and to support others		IDI with IPs
Beneficiaries (adolescent mothers and peer educators) were able to transmit the message on SRH to the community during community meetings (Umuganda/community work, evening family forums, Inteko y'abaturage…) Peer educators have now knowledge about SRH as well as the capacity to spread the message in the community Knowledge about SRH is contagious. Beneficiaries transmit it even during the dating, when sexual intercourse is being negotiated, those who are trained inform those who are not		FGD with IPs
Trained peers are in constant contact with peer educators for day today advise in every cases, they know where to get information, even what they have forgotten or when they are doubting of the decision they want to make SRH training/msg is delivered to the General Assembly of the youth at district level (youth council and youth volunteers), then trained people cascade the message to sector level		FGD with IPs KII with Local lead
UNFPA and partners support the activities/interventions which are already in the district's plan, which means that these activities will continue even after these partners have left, although at limited pace if the financial situation at local level remains. So partners only bring the top up on what the district is doing, which gives hope of sustainability.		KII with Local lead
UNFPA support government programmes and institutions: e.g. youth corners within health centres, community outreach is done by health workers. Beneficiaries are identified in collaboration with local leaders at district		KII with CO

level, and local leaders are the one monitoring the intervention at local level	
The programme works with the youth councils who will remain there. They work also with the umbrella of the youth-led organisation (AfriYAN), involve national youth council, which can assure the sustainability It is possible to learn from what the programme achieved in the three districts and to address the matter in other districts We have happened to convince decision makers where the cabinet has recently approves the waiver of taxes for hygienic products (although the implementation is still in process)[89] Local communities who are involved are doing well, there is hope of sustainability Local communities working with the programme are doing well (Friends of families, social affairs VM/staff, peer educators, schools We worked with the communities but reached refugee camps as well. Both refugees and the community have the same SRH understanding and the knowledge is likely to remain	IDI with IPs
Youth are trained in the community and they communicate the message with other youth informally (when chatting, during the meeting, at home), which ensure the sustainability	KII with Local lead; FGD with IPs
Adolescent mothers contribute much in the community, communicating about SRH: Family evening forums, community meetings, Infrastructures (health centre, youth corner…) will remain if the camp is removed. The refugees are also using local services such as market (food, clothes…), which contribute to the development of the surrounding area. Skills and awareness (tailoring, FP, saloon) will also contribute to the self-development among those who received them)	FGD with IPs
AfriYAN is now recognised as technical working group at national level (in the midst of government institutions, NGOs, and partners) we are influencing the programming in Rwanda. Rwanda signed ICPD commitment where the youth contributed much, 4/12 delegates to Nairobi summit (2019) were the youth. AfriYAN is the one who inspired annual follow up of 4 year programme which will end in 2024 (The initial follow up was in 2022).	IDI with IPs
Sustainability of youth service seems difficult in refugee camps since all is working upon the peer educators' activities and the monthly incentive they receive. Without this incentive, it is hard to see how activities would continue. In addition, children are growing and these still need to be advised and informed.	FGD with IPs
The frustration related to sex can block the development (adolescent mothers not daring to be confident, dropping out of school, being rejected by the society…). So breaking it is a great achievement and the door to	KII with Local lead

[89] The removal took place in 2019. [Isimbi, Ynis (2020). Removing VAT on sanitary products in Rwanda does not end the war on period poverty. LSE. https://blogs.lse.ac.uk/africaatlse/2020/01/16/rwanda-vat-sanitary-products-period-poverty/] or https://www.ktpress.rw/2019/12/rwanda-scraps-value-added-tax-on-sanitary-pads/

development, freedom, and confidence		
Assumptions for verification 4.2: Types of mechanisms put in place by 8th CP to ensure durable effects of the CP	**Indicators:** **I.1: Evidence of mechanisms established by the 8th CP (policies, strategies, infrastructure, networks etc)**	**Methods and tools for data collection:** Document reviews Interviews with UNFPA CO staff
Data collected		***Source of information***
SRH programme is mixed with economic empowerment: Hair cut saloon The SRH awareness has reached the community at all levels. Community members can teach, advise, rebuke each other Trained Abafashamyumvire (community educators) are everywhere in the community Peer youth are equipped with knowledge and skills in SRH		KII with Local lead
SRH being integrated into religious strategic planning		IDI with IPs
"In order to harmonize the provision of services at different levels, UNFPA's support to the MoH/RBC also enabled the development of FP guidelines and standards, which were also validated in the Family Planning TWG and the RMNCAH TWG."		Documents review

Evaluation Question 5: To what extent to which UNFPA has been an active member of and contributor to existing coordination mechanism of the UNCT including membership of and contribution to Humanitarian coordination mechanisms of the HCT, where applicable? To what extent to which the UNFPA CO harmonised interventions with other actors promote synergy and avoid duplication?		
Evaluation Criteria: [*Coordination*]		
SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS		
Assumptions for verification 5.1: UNFPA was actively involved in coordination structures for the Outcomes in UNCT	**Indicators:**	**Methods and tools for data collection:**
	I.1: Evidence of UNFPA membership and participation in SRH, AY and Data coordinating structures	● **Documents review**
	I.2: Evidence of collaboration and joint programming with other United Nations agencies in the Outcome areas	● **Interview with CO and UNCT staff**

	1.3 Evidence of UNFPA contribution to UNCT coordination	● **Documents review**
	1.4 Evidence of UNFPA leadership within the UNCT	● **Documents review**
UNFPA actively engaged in the management and coordination structures established in support of the 2022 Census including the technical and steering committees on Data and Statistics		**Interviews with UNFPA CO staff,**
Improved coordination and collaboration of independent private health post operators with public health systems have greatly improved access and availability of healthcare services at the community level (Health posts). (Supportive supervision, mentorships, regular review of service statistics to improve quality of care, supply chain, capacity building…).		**Interviews with UNFPA CO staff,**
The funds are allocated for a duration of three months initially, with an additional three-month disbursement contingent upon the approval of the preceding three-month report. This delay and disruption to our work are primarily attributed to the extended timeframe required for administrative processes, often characterized by bureaucratic procedures.		Health Development Initiative, Research Director And Rwanda Association of Midwives (RAM), Midwifery School
The UNCT convened talks to address the requirements for supporting Rwanda in achieving the outcomes outlined in the Cooperation Framework. The United Nations development system in Rwanda is firmly dedicated to utilizing its unique strengths to assist both the government and non-governmental entities in reaching the goals of NST1 and the SDGs, all while maintaining essential programming principles. The UNCT and partners lead support to youth in economic activities, social wellbeing, sexual and reproductive health, mental health, and tailored programs		**Interviews with UNFPA CO staff,**
The district lacks clear information about the partners' schedules. Partners visit the district office and commence their work, but subsequently, there may be reports of their relocation to different areas or the conclusion of their programs.		Rusizi Vice Mayor Social Affairs
Assumptions for verification 5.2: ***UNFPA was actively involved in coordination mechanism of humanitarian coordination team.***	**Indicators:**	**Methods and tools for data collection:**
	I.1: Evidence of UNFPA activities in HCT actions	● **Document review and** Country Office Annual Report
	I.2: Evidence of UNFPA contribution to HCT coordination	● **Interview with CO Staff**
UNFPA Rwanda has been working closely with its Implementing Partners (IPs) to achieve the three transformative results in Rwanda		**Interviews with UNFPA CO staff,**

For the collaborative efforts, work plans are signed by both the IPs and UNFPA as a formal document and as the main tool for planning, budgeting and monitoring of the activities that contribute to programme outputs outlined in the 8th Country Programme Document. Periodic monitoring (both the progress and the financial expenditure) and reporting of the work plans should be performed as stated in the UNFPA's Policy and Procedures for Preparation, Management and Monitoring of Work Plans (PPM), which states that the review meetings with all implementing partners must take place on the annual basis.		**Interviews with UNFPA CO staff,**
ADOLESCENTS AND YOUTH		
Assumptions for verification 5.1: **UNFPA was actively involved in coordination structures for the Outcomes in UNCT**	**Indicators:** **I.1: Evidence of UNFPA membership and participation in SRH, AY and Data coordinating structures** **I.2: Evidence of collaboration and joint programming with other United Nations agencies in the Outcome areas** **1.3 Evidence of UNFPA contribution to UNCT coordination** **1.4 Evidence of UNFPA leadership within the UNCT**	**Methods and tools for data collection:** Documents review Interview with CO and UNCT staff
Data collected		***Source of information***
UNFPA was appointed by the UNCT to chair Result Group 2 "Social Transformation: Human Capital and Demographic Dividend." RG2 is the biggest Result Group of the UNDAP in terms of the allocated budget and number of participating United Nations agencies. As Chair of the RG2, UNFPA led a joint programme on youth including youth-friendly health services and reduction of adolescent pregnancies, which are among the priorities of the RG.		Documents review
At UNCT level, UNFPA Rep designated as lead focal point and has established an in-country network on PSEA across the Agencies and develop a country-level action plan. UNFPA Representative presented progress to the UNCT 2019 Retreat (14 March 2019), key findings from the global safe space survey, and integrated PSEA inter-agency network activities into 2019 UNCT workplan for prioritization and accountability		
Finally, UNFPA Rwanda is among the few countries who contributed to the first report of the High level commission on ICPD25 follow up "No Exceptions, No Exclusions: Realizing sexual and reproductive health, rights and justice for all " that marked the 2nd anniversary of the Nairobi summit		

UNFPA remained actively engaged in the COVID-19 national response coordination forums including UNCT, CMT, inter-agency COVID coordinators, DP Groups on Health, and on Social Protection, supply chain management, and health sector response to GBV as part of a multi-sectoral approach.	

Evaluation Question 6: To what extent to which activities of a short-term emergency nature are carried out in a context that takes longer-term and interconnected problems into account?		
Evaluation Criteria: [*Connectedness*]		
SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS		
Assumptions for verification 6.1: Country Programme SRHR and AY humanitarian interventions were targeted at and delivered in all geographical areas where affected populations reside	**Indicators:**	**Methods and tools for data collection:**
	I.1: Evidence of mapping SRHR/AY humanitarian interventions to all affected geographical areas.	**●Document review**
	I.2: Evidence of the types of humanitarian interventions implemented	**● Interview with CO Staff**
	1.3 Evidence of people reached (target vs actual results) against people who needed the services	**● Interview with CO Staff Document review**
	1.4 UNFPA humanitarian response in SRHR and AY were aligned to long-term development goals in the 8th CP results framework	**● Interview with CO Staff Document review**
The United Nations Country Team is dedicated to aiding the Rwandan government in accomplishing its National Strategy for Transformation (2017 – 2024) and Sustainable Development Goals' objectives. Furthermore, it aims to foster regional integration, peace, and security, aligning with the Africa Union Agenda 2063 and East African Vision 2050. To this end, the United Nations in Rwanda is resolutely committed to contributing to Rwanda's enduring economic and social transformation. This transformation hinges on principles such as good governance, the protection of human rights, the establishment of justice, the promotion of peace and security, the advancement of gender equality and equity, active participation in inclusive and sustainable economic development, the creation of decent job opportunities, and ensuring equitable access to and utilization of high-quality essential social and protection services within a sustainable and climate-resilient environment.		2022 Annual Report - Rwanda
The UNCT and partners lead support to youth in economic activities, social wellbeing, sexual and reproductive		**Interviews with UNFPA CO staff,**

health, mental health and tailored programs including in humanitarian areas.	

Evaluation Question 7: To what extent to which the institutional monitoring and evaluation system of the programme has enabled the effective collection, circulation and reporting of data, favouring the monitoring of the achievement of the results, the decision-making and accountability of the programme?		
Evaluation Criteria: [*Cross-cutting – Monitoring and Evaluation System*]		
SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS		
Assumptions for verification 7.1: UNFPA CO has a systematic M&E procedure	**Indicators:**	**Methods and tools for data collection:**
	I.1: Evidence M&E collecting and reporting data favouring the monitoring of the achievement of the results	● **Document review**
	I.2: Evidence on how recommendations have been used in the 8th CP	● **Interviews**
The M&E process for UNFPA's 8th Country Programme in Rwanda was a comprehensive and dynamic system that focuses on collecting and reporting data aligned with programme outcomes. It aimed to provide actionable insights for programme improvement and to ensure the achievement of programme goals.		Interviews with UNFPA CO staff,
Following UNFPA results-based management guidelines, it was designed a monitoring and evaluation plan with tools for monitoring, reporting and communicating achievements for accountability to donors and beneficiaries. Implementation complied with the harmonized approach for cash transfers and was monitored through field visits and spot checks, in collaboration with other United Nations agencies, as set in corporate guidelines. UNFPA complied with targets and cost-efficiencies identified through the implementation of the new business operation strategy. Annual programme reviews and work planning was informed by monitoring and evaluation data as well as environmental scanning findings; if required, corrective measures to accelerate achievements of planned results were taken.		Health Development Initiative, Research Director (Louange Twahirwa, RBC - MCCH Division, Director of Health Facility Programs Unit (Dr Francois Regis CYIZA), And Rwanda Association of Midwives (RAM), President, Josephine Murekezi, Midwifery School (Tengera Olive).
Assumptions for verification 7.2: *UNFPA CO has a communication system*	**Indicators:**	**Methods and tools for data collection:**
	I.1: Evidence of communication results	● **Document reviews**

The Healthy and Empowered Youth Project has collaborated closely with UNFPA's specialist in disability and inclusion to ensure that the project implementation incorporates the distinct requirements of young people with disabilities (PWD).	Health Development Initiative, Research Director (Louange Twahirwa), And Rwanda Association of Midwives (RAM), President, Josephine Murekezi, Midwifery School (Tengera Olive), UNFPA SRH Unit Lead (Marie Claire Iryanyawera.
The provider of support should also ensure that the aid they offer has the potential to establish individuals within the business sector. In some cases, an inadequate amount of support can lead to time wastage or failure, such as the inability to secure a market space for a small business or insufficient means to sustain oneself while raising domestic animals. Having a sufficient amount of financial assistance can facilitate the payment of taxes, provide stability in the market, rather than operating clandestinely to evade law enforcement and its associated risks, and allow individuals to maintain a recognized address for their business activities.	FGDs from Kanjongo adolescent mothers
Transform sexual and reproductive health (SRH) promotion for young people into a family-oriented initiative by providing training to parents. This approach is necessary because parents are expected to play a role in educating their children about SRH, but they themselves require awareness and education on this topic. Presently, parents may not be very open with their children regarding SRH, and they may lack the appropriate knowledge and messaging to convey to their children. Elevating parents' awareness levels will empower them and enhance their willingness to engage in open discussions, ultimately making them more effective in promoting SRH among young people.	Vice Mayor Social affairs of Rusizi
SRH services should be decentralized at the village levels so that youth should access this service in their communities. It would be better to SHR permanent at the village level who come from other region to avoid the disclosure of information when the youth has accessed the SRH service. The confidently mothers.	Vice Mayor Economic Affairs of Nyamasheke
There is a need to make the company in community and in hospitals. E.g. in Kanjongo, a adolescent mother wanted to have a FP, she has her sister-in-law, she is well known because she is working at the Kibogora Hospital, she told this adolescent that if she gets the FP, this indicates that she is a continuous prostitute. Now, she cannot get the FP because her sister-in-law is well connected with all Nyamasheke health centres.	FGDs from Kanjongo adolescent mothers
There is no permanent staff for SRH in Rubengera. Youth spend more time to get services because this service does not its full-time staff. The youth recommend to have a staff at their age because approaching them is easy and they can feel comfortable to talk to them about their issues on the SRH.	Rubengera Adolescent mothers FGDs
It is essential to shift the emphasis of sexual and reproductive health (SRH) promotion away from exclusively targeting girls and instead include boys. Boys lack adequate information and awareness about SRH matters. The effort that is currently dedicated to educating girls should also be directed toward educating boys and, in general, men. Boys and men should be informed about the consequences of unintended pregnancies and should learn how to contribute to prevention. Providing boys and men with SRH training is crucial because they do not possess comprehensive knowledge in this area. This education would enable them to continue their role in	Vice Mayor Social affairs of Rusizi

reducing unprotected sexual activities effectively.		
There is a small room in camps youth corners, the hall to entertain is very small this makes youth bored and pushes them to be involved in illicit alcohols.		Mahama and Kiziba FGDs with peers educators.
ADOLESCENTS AND YOUTH		
Assumptions for verification: 7.1: UNFPA CO has a systematic M&E procedure	**Indicators:** **I.1: Evidence M&E collecting and reporting data favouring the monitoring of the achievement of the results** **I.2: Evidence on how recommendations have been used in the 8th CP**	**Methods and tools for data collection:** Document review Interviews
Data collected		***Source of information***
UNFPA's 8th CP has annual and quarterly reports		Document review
UNFPA's 8th CP has M&E reports		
"During this reporting quarter, UNFPA undertook various regular monitoring visits to project field sites to observe, advise and supervise, and monitor the progress of the 8th CP activities. This included i) a monitoring visit to 3 key districts to meet district officials and First Time Young Mothers representatives to take stock of successes and challenges relating to FTYM's economic empowerment activities (jointly with Imbuto Foundation, GNI, AfriYAN youth network, Rwanda national association of deaf women)"		
An effective planning, monitoring and evaluation system is in place and continuously strengthened at the CO. "In line with the 2022 Office Management Plan, Annual Work Plans were developed and monitored. Regular monitoring visits were conducted including high level joint visits with donors (KOICA, Japan) that helped showcase results achieved, documentation of human interest stories, increased visibility for donors and strengthened partnerships with IPs and with donors. Quarterly reporting by IPs and internal corporate reporting were undertaken on time and donor reports submitted in a timely manner"		
Lack of monitoring of the implemented intervention. E.g. CSE in schools (trained teachers). UNFPA does not know the content and the methodology used in CSE Coordination of activities in health centres is missing " The biggest challenge faced related to the unavailability and limited number of CSE Master Trainers from the Rwanda Education Board who were supposed to coordinate and deliver the training of teachers including monitoring the delivery of CSE. This resulted in considerable delays in the start of training and negatively		KII with CO Document review

impacted the quality of training. "	
Community outreaches are missing where all partners would go together to the field to see interventions There is no visible plan to follow in the implementation of this programme for the stabilisation of the project within the community	IDI with IPs

Evaluation Question 8: To what extent the institutional communication mechanism has enabled the dissemination of the program's actions to the beneficiaries and other stakeholders and ensured the visibility of its interventions both internally and externally?		
Evaluation Criteria: [*Cross-Cutting: Gender equality and human rights, Communication, monitoring and evaluation, resource mobilisation and innovations)*		
SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS		
Assumptions for verification 8.1: The needs of vulnerable populations were well taken into consideration and human rights integrated across programmes.	**Indicators:**	**Methods and tools for data collection:**
	I.1: Evidence of human rights focus in all outcome areas	
8.2 Gender was mainstreamed into all components during the programming process	**I.2: Evidence of gender mainstreaming in outcome areas**	• **Document reviews**
	…	• **Interview with CO staff**
A human rights-based approach (HRBA) is significantly embedded into the work of the UNFPA, especially in addressing laws and policies that undermine access to sexual and reproductive health, and in working to prevent and protect young women and girls from violence. Based on this the evaluation assessed the extent to which issues of human rights, equity, gender equality and disability inclusion for the project and found that this was well demonstrated from the project design, inception and implementation. The overall project focuses was on youth who are 10–24 years with a specific focus on adolescent mothers. Enhanced inclusion on PWDs was evidenced by the UNFPA Rwanda Country Office organizing a training on disability mainstreaming for its staff and implementing partners in August 2022. Where a total 57 participants (26 Females and 31 Males) including 27 attendees from UNFPA partners and 30 UNFPA staff members attending the training (MUSHIMIYIMANA, 2022). The project celebrated the commemoration of International Day of Persons with Disabilities (IDPD) in 2021 and 2022 in Nyamasheke and Rusizi respectively. In 2021, IDPD was undertaken for two weeks (November – December 2021)[2], reaching 1,010 adolescents and youths		Document reviews, KII and IDI

living with disabilities; additional 40 parents and 30 leaders in Nyamasheke district. In the 2022 celebrations a total of 154 people (66 females, 88 males) participated in three dialogue sessions; this included 48 persons with Disability counting for more than 30% of the total particpants.[3] Furthermore, the selection and the inclusion of the FTYMs in the project area following a well-defined criterion set by the IPs with the support of local leaders. Having the well-defined criteria ensured selection of deserving cases and prevention of any duplication of beneficiaries who are benefitting livelihoods assistance from other programs. The criteria was shared through meetings with partners and leaders working with various IPs, in order to ensure inclusivity and transparency to all	

Annex 2: List of documents consulted

UNFPA documents
UNFPA Strategic Plan (2014–2017) (incl. annexes)
https://www.unfpa.org/resources/strategic-plan–2014–2017
UNFPA Strategic Plan (2018–2021) (incl. annexes)
https://www.unfpa.org/strategic-plan–2018–2021
UNFPA Strategic Plan (2022–2025) (incl. annexes)
https://www.unfpa.org/unfpa-strategic-plan–2022–2025-dpfpa20218
UNFPA Evaluation Policy (2019)
https://www.unfpa.org/admin-resource/unfpa-evaluation-policy–2019
Evaluation Handbook: How to Design and Conduct a Country Programme Evaluation at UNFPA (2019)
https://www.unfpa.org/EvaluationHandbook
Relevant centralized evaluations conducted by the UNFPA Evaluation Office (list all evaluations individually and provide the direct hyperlink to each report) - available at: https://www.unfpa.org/evaluation

Rwanda national strategies, policies and action plans
National Strategy for Transformation (NST 1, 2017–2024)
https://vision2050.minecofin.gov.rw/root/nst/nst1
United Nations Sustainable Development Cooperation Framework (UNSDCF, July 2018- June 2024)
UNSDG | UNCT Key Documents
Fourth Health Sector Strategic Plan (HSSP IV, July 2018- June 2024)
https://vision2050.minecofin.gov.rw/fileadmin/user_upload/Publications/SSPs/HEALTH.pdf

UNFPA Rwanda CO programming documents
Government of Rwanda/UNFPA 8th Country Programme Document (July 2018 – June 2024)
United Nations Common Country Analysis
Situation analysis for the Government of Rwanda/UNFPA 8th Country Programme (July 2018 – June 2024)
CO annual work plans
Joint programme documents
Mid-term reviews of interventions/programmes in different thematic areas of the CP
Reports on core and non-core resources
CO resource mobilization strategy

UNFPA Rwanda CO M&E documents
Government of Rwanda/UNFPA 8th Country Programme M&E Plan (July 2018 – June 2024)
CO annual results plans and reports (SIS/MyResults)
CO quarterly monitoring reports (SIS/MyResults)
Previous evaluation of the Government of Rwanda/UNFPA 8th Country Programme

(July 2018 – June 2024), available at:
https://web2.unfpa.org/public/about/oversight/evaluations/

Other documents

Implementing partner annual work plans and quarterly progress reports
Implementing partner assessments
Audit reports and spot check reports
Meeting agendas and minutes of joint United Nations working groups
Donor reports of projects of the UNFPA Rwanda CO
Programmatic Guidance on Integrating Adolescent Sexual and Reproductive Health and Rights and Economic Empowerment of Young People.
Presentation of Preliminary Results of the Mapping Of Out-Of-School A&Y And Vocational Training Structures (Formal And Informal) In Karongi, Rusizi And Nyamasheke.
2018 MHTF Annual Report on Progress and Results Achieved.
2019 MHTF Annual Report on Progress and Results Achieved.
Advancing Policy and Normative Support in UNFPA Programming PSD in collaboration with ESARO and UNFPA Rwanda 13 – 14 December 2018, Kigali, Rwanda.
UNFPA Strategic Investment Facility, 20222 End of Year Report.
The Out of School Adolescents and Youths Resilience Plan Implementation Progress Report.
Joint Monitoring Field Visit to Review the Effectiveness of the Implementation of Socio-Economic Activities in Primary and Secondary Schools and in TVETs for Adolescents and Young People RUSIZI.
Out of School Adolescents and Youths Resilience Plan for Karongi, Nyamasheke and Rusizi.

Table: Stakeholder sampling at national and district levels

Stakeholders suggested for KIIs/FGDs		**Outcome**		
		Outcome 1: SRH	**Outcome 2: A&Y**	**Outcome 4: P&D**
Key Informant Interviews - National / Kigali				
Government	Ministry of Youth		X	
	Ministry of Health	X	X	
	Rwanda Education Board		X	
	Rwanda Biomedical Centre (RMNCAH, HIV, NCD/disability inclusion divisions)	X	X	
Direct IPs	National Institute of Statistics of Rwanda			X
	Imbuto Foundation	X	X	
	Society For Family Health (SFH)	X	X	
	Health Development Initiative	X	X	
	Swiss Tropical and Public Health Institute (STPH)	X	X	
	College of Medicine and Health Sciences / School of Midwifery	X		
	ALIGHT	X	X	
	AHA	X	X	
	Network of Rwandan Parliamentarians on Population and Development (RPRPD)			X
	Good Neighbors International (GNI)	X	X	
Other IPs	Rwanda Association of Midwives	X	X	
	Rwanda Interfaith Council on Health	X	X	

	African Youth and Adolescent Network (AfriYAN)	X	X	X
United Nations partners	United Nations Children's Fund	X	X	X
	World Health Organization	X		X
	Resident Coordinator's Office			
Donors	ENABEL	X	X	
	KOICA	X	X	
UNFPA Rwanda CO, Kigali	Head of Programme & Assistant Rep (also as the P&D Lead)			
	SRHR Outcome Lead	X		
	AY Outcome Lead		X	
	Communications Lead	X	X	X
	M&E	X	X	X
	Gender & Human Rights officer	X	X	X
Karongi District				
UNFPA District Programme Coordinator & district authorities		X	X	X
Beneficiaries of UNFPA support	FGD Beneficiaries: SRHR beneficiaries	X		
	FGD Beneficiaries: Youth interventions beneficiaries - e.g. youth graduates from out-of-school CSE and resilience plan (implemented by Swiss TPH), adolescent mothers and peer educators (by Imbuto, GNI), youth corner/health centre SRH staff		X	
Nyamasheke District				
UNFPA District Programme Coordinator & district authorities		X	X	X
Beneficiaries of UNFPA support	FGD Beneficiaries: SRHR beneficiaries	X		
	FGD Beneficiaries: Youth interventions beneficiaries - e.g. youth graduates from out-of-school CSE and resilience plan (implemented by Swiss TPH), adolescent mothers and peer educators (by Imbuto, GNI), youth corner/health centre SRH staff		X	
Rusizi District				
UNFPA District Programme Coordinator & district authorities		X	X	X
Beneficiaries of UNFPA support	FGD Beneficiaries: SRHR beneficiaries	X		
	FGD Beneficiaries: Youth interventions beneficiaries - e.g. youth graduates from out-of-school CSE and resilience plan (implemented by Swiss TPH), adolescent mothers and peer educators (by Imbuto, GNI), youth corner/health centre SRH staff		X	
Mahama camp (Alight, Save the Children)				
	Camp officers	X	X	X
	FGD Beneficiaries: SRHR beneficiaries	X		
	FGD Beneficiaries: Youth interventions beneficiaries - e.g. First time young mothers, peer educators, community health workers, health coordinators/SRH staff, refugee leaders, camp authorities, etc (IP by Alight/ official UNHCR partner with Save the children since 2023)		X	
Kiziba camp (AHA, Save the Children)				

	Camp officers	X	X	X
	FGD Beneficiaries: SRHR beneficiaries	X		
	FGD Beneficiaries: Youth interventions beneficiaries - e.g. First time young mothers, peer educators, community health workers, health coordinators/SRH staff, refugee leaders, camp authorities, etc (IP by AHA / official UNHCR partner with Save the children since 2023)		X	

Annex 3: List of persons met and their organisational affiliations/institutions

Date	Time	Activity/ Institution	Person to meet	Position/role	Stakeholder category	Link with CP output and outcome	Site location	Telephone number (s)	Email address	Notes
Week 1: 24–28 July 2023										
24/07/23	9:00 - 10:00am	KII/UNFPA	Renata Tallarico	Deputy Representative	UNFPA		UNFPA Office	0788318597	tallarico@unfpa.org	
24/07/23	9:00 - 10:00am	KII/UNFPA	Kathy Kantengwa	Assistant Representative	UNFPA		UNFPA Office	0788307855	kantengwa@unfpa.org	
24/07/23	11:30 - 12:30am	KII/UNFPA	Vestine Mutarabayire	Adolescents & Youth Unit Lead	UNFPA		UNFPA Office	0788510540	muterabayire@unfpa.org	
25/07/23	10:00–11:00am	KII/ALIGHT	Chantal Uwambaza	Programmes Coordinator,	CSO		Online	078850702	chantalu@wearealight.org	
25/07/23	02:00–03:00pm	KII/UNFPA	Marie Claire Iryanyawera	SRH Unit Lead	UNFPA		UNFPA Office	0788303374	iryanyawera@unfpa.org	
25/07/23	03:00–04:00pm	KII/UNFPA	Julienne Nyiramayira	Operations Manager	UNFPA		UNFPA Office	0786006763	nyiramayira@unfpa.org	
25/07/23	04:00–05:00pm	KII/UNFPA	Hakyung Kang	M&E Specialist	UNFPA		UNFPA Office	0789827542	hkang@unfpa.org	
26/07/23	09:30 – 10:30am	KII/ MINIYOUTH	Mr Phenias Mutabazi		Government		UNFPA Office	0783648775	pmutabazi@miniyouth.gov.rw	
26/07/23	09:00 – 10:00am	KII/National Institute of Statistics in Rwanda	Emmanuel Mupende	SPIU M&E Specialist	Government		Online	0783886139	emmanuel.mupende@statistics.gov.rw	
26/07/23	02:30-03:00pm	KII/UNFPA	Charlotte Mbungo	Communications Analyst	UNFPA		UNFPA Office		mbungo@unfpa.org	
26/07/23	04:00–04:30pm	KII/UNICEF	Pascal Karemera	M&E Specialist	UN Agency		Online	0788309308	pkaremera@unicef.org	
27/07/23	09:00 – 10:00am	KII/Swiss TPH	Ernest Mendy	Project Coordinator	CSO		Online	0783647852	ernest.mendy@swisstph.com	
27/07/23	02:00–03:00pm	KII/Health Development Initiative	Louange Twahirwa	Research Director	CSO		Online	0788303908	louange@hdirwanda.org	
27/07/23	03:30–04:30pm	KII/African Humanitarian Action (AHA)	Mulugeta Tenna	Senior Health and Programme Coordinator	CSO		Online	0788232742	mulugetatenna59@gmail.com	
28/07/23	09:00–10:00am	KII/RPRPD	Jean Marie Mbonyintwali	Advocacy and Partnership Advisor	CSO		Online	0788859946	jm.mbonyintwali@parliament.gov.rw	

Date	Time	Activity/ Institution	Person to meet	Position/role	Stakeholder category	Link with CP output and outcome	Site location	Telephone number (s)	Email address	Notes
28/07/23	11:00–12:00pm	KII/GNI	Vincent Ikibasumba		**CSO**		GNI's office	0788475377	vincent.gnr@goodneighbors.org	
28/07/23	02:00–03:00pm	KII/Rwanda Association of Midwives (RAM)	Josephine Murekezi	President	**CSO**		Online	0788624083	jrekezi74@gmail.com	
28/07/23	02:00–03:00pm	AfriYAN	Evode Niyibizi	President	**CSO**		AfriYAN's office	0787185148	evode@afriyanrwanda.org	
28/07/23	05:00 –06:00pm	KII/Midwifery School	Tengera Olive		Government		Online	0788429834	tengera.olive@gmail.com	
30/07/23	03:00–04:00pm	KII/Rwanda Interfaith Council	Eraste Ntihemuka	Head of Programs	CSO		Online	0788307211	**erasten@rwandainterfaith.org**	
Week 2 :31 July–04 August 2023										
01/08/23	08:30am–09:15:00am	RBC - MCCH Division	Francois Regis Cyiza	Director of Health Facility Programs Unit Maternal, Child and Community Health Division	Government		Online		francoisregis.cyiza@rbc.gov.rw	
02/08/23	11:00 am–11:30am	ENABEL	Mary Hadley			**All**	Online		mary.hadley@enabel.be	
Week 3: 07 August–11 August 2023										
07/08/23	10:00–11:00am	FGD (1 hour)	Young people who benefited from UNFPA's support	Adolescent mothers	Beneficiaries	Programme Area: A&Y	Rubengera youth centre		ernest.mendy@swisstph.ch	
	02:00–03:00pm	FGD	Young people who benefited from UNFPA's support	Peer Educators	Beneficiaries	Programme Area: A&Y	Rubengera Sector			
	03;00–04:00pm	FGD	Young people who benefited from UNFPA's support	Peer Youth who benefited from CSE out of School resilient Plan	Beneficiaries	Programme Area: A&Y	Rubengera Sector			
	10:00–10:30AM	KII/Rubengera Health Centre	Egide Nizeyimana	Nurse in charge of youth corner	Government		Rubengera Youth Centre	0788425908		

Date	Time	Activity/ Institution	Person to meet	Position/role	Stakeholder category	Link with CP output and outcome	Site location	Telephone number (s)	Email address	Notes
	3:00–3:45pm	KII/Karongi District		Vice Mayor in Charge of Social Affairs	Government	All	Karongi District Office			
	2:00–2:30pm	KII/Swiss TPH	Pacifique Ntwali	Youth Supervisor	CSO	Adolescent and Youth	Rubengera Sector	0788497091		
08/08/23	03:00–04:00	KII/Nyamasheke District		District Vice Mayor in charge of Economic Planning	Government	All	Nyamasheke District office			
	04:30–05:00pm	KII/UNFPA	Pascal Nasabimana	UNFPA District Programme Coordinator/Nyamasheke	UNFPA	All	Nyamasheke	0788414624	nzasabimana@unfpa.org	
09/08/23	08:00–08:45am	KII/Kibogora Health Centre	Nyiraneza Berancille	Nurse/Kibogora Youth Corner	Government		Kibogora Health Centre	0788287523		
	10:00–11:00am	FGD	Adolescent mothers	Adolescent mothers	Beneficiaries	Programme Area: A&Y	Kibogora Health Centre			
	12:00–01:00pm	FDG	Young people who benefited from UNFPA's support	Youth who benefited from the CSE out of school resilient Plan	Beneficiaries		Nyamasheke youth centre			
10/08/23	11:00–12:00PM	KII/Health Centre		Nurse Entrepreneur	Beneficiaries	SRH	Muti Health Centre			
10/08/23	08:00–09:00	KII/Rusizi District	Anne Marie Dukuzumuremyi	Vice Mayor in charge of Social Affaires	Government	All	Rusizi District office	0788883064		
Week 4: 14 –18 August 2023										
14/08/23	09:30–10:30	KII /Alight staff	Happy Joselyne Mukanoheri		CSO	SRH + AY	Mahama Camp	**0788876568**		
	09:30–10:30	KII /Alight staff			CSO	SRH + AY	Mahama Camp			
	11:00–12:00pm	FGD	Young people who benefited from UNFPA's support	Adolescent Mothers	Beneficiaries		Mahama Camp			
	01:00–	FGD	Young people	Peer Educators	Beneficiaries					

Date	Time	Activity/ Institution	Person to meet	Position/role	Stakeholder category	Link with CP output and outcome	Site location	Telephone number (s)	Email address	Notes
	02:00pm		who benefited from UNFPA's support							
	09:00–10:00	KII/AHA Camp staff	Jean Jacques Safari Musirakumva		CSO	SRH + AY	Kiziba camp	0783606985		
	09:00–10:00	KII/AHA Camp staff	Ange Dusabe		CSO	SRH + AY	Kiziba camp	0788623886		
	09:30–10:30am	FGD	Young people who benefited from UNFPA's support	Peer Educators	Beneficiaries	SRH + AY	Kiziba camp			
17/08/23	11:00–12:00pm	FGD	Young people who benefited from UNFPA's support	Adolescent Mothers	Beneficiaries	SRH + AY	Kiziba camp			
Week 5: 21–25 August										
22/08/23	11:00–12pm	KII/KOICA	Felix Ngiriabakunzi	Programme Manager	Donor					
	11:00–12pm	KII/KOICA	Patience Mutesi	Programme Officer	Donor					
	03:00–04:00pm	KII/Ministry of Health	Theoneste Mutsidashyaka	Sector M&E and Reporting Specialist	Government		MOH office			
	03:00–04:00pm	KII/Ministry of Health	Tubane Emmanuel	Health Information Systems and Data Management Specialist	Government		MOH office			

Annex 4: Interview guides for different stakeholders

Relevance

1 To what extent does the UNFPA Rwanda 8th CP align with Rwanda's development needs and priorities; UNFPA's global and regional Strategic Plans; the needs of the intended beneficiaries namely women, young people and other vulnerable populations

2 To what extent any unintended consequences or negative impacts on the intended and unintended beneficiaries or other stakeholders and how they were addressed?

Effectiveness of the programme

What are the main successes and achievements of the 8th UNFPA Country Programme in Rwanda so far? Specify for each of the three components (SRHR, A&Y, and PD).

What were the main internal weaknesses of the programme and what were the most important external challenges?

What was done by UNFPA Rwanda and what was done by partners to address those weaknesses or challenges?

Do you think that the CP is covering all the needs in your programme area? Are there any areas which should be reoriented or added to better address the needs and achieve results?

Partnerships

What is the quality of UNFPA's partnerships with implementing agencies and what can be done to improve them?

What is the quality of UNFPA's partnerships with government authorities supported and what can be done to improve them?

What is the quality of UNFPA's partnerships with the donors and what can be done to improve them?

Which other partner (s) do you think UNFPA Rwanda should work with in the future to achieve better programmes?

Efficiency

Resource mobilization: Has the country office mobilized enough financial resources vis-à-vis what was needed to implement planned programme outputs? What was the rate or planned resources versus what was raised? If no, what can be done to improve CO resource mobilization strategies?

Did the country office devote the required human and technical resources for efficient programme implementation? For a timely disbursement of allocated funds? To support implementing partners in the technical areas of their programs? What were the challenges or impediments and how can they be addressed in future programs?

Coordination

To what extent was the UNFPA programme in Rwanda aligned with and contributing to the priorities of the wider humanitarian and development systems as set out in the UNDAF, successive Rwanda Humanitarian Response Plans, and the Regional Refugee Response Plan, and the UNFPA mandate and policies?

What were the mechanisms of coordination between different stakeholders to achieve tangible results of the SRHR, adolescents and youth, and population dynamics-related advocacy efforts?

To what extent has the county office contributed to the functioning and consolidation of UNCT and HCT coordination mechanisms?

What is UNFPA's role in UNCT and HCT coordination mechanisms? In what ways is UNFPA contributing to the existing coordination mechanisms?

To what extent UNFPA has organized its interventions to maximize the HCT joint effects, e.g. with GBV programs of UNHCR and RH ones with UNICEF?

Sustainability

To what extent did the programme help to establish building blocks/factors for the future sustainability of SRHR /youth/gender / GBV and population services in Rwanda, and for the interventions implemented by partners which are supported by the programme? Explain how?

Can the Government of Rwanda and other stakeholders continue implementing current interventions without UNFPA support? Please elaborate.

Which are the main lessons learned from the programme for UNFPA and for government authorities?

Connectedness
To what extent did UNFPA humanitarian activities support or contribute to the transitioning towards longer-term (i.e., developmental and/or resilience-related) goals of the affected populations?
-How can UNFPA build capacities of IPs – NGOs and Governments – to facilitate the transition from humanitarian to development
What should be the role and responsibilities of UNFPA in a more developmental context as compared to a humanitarian context?
How can UNFPA build capacities of IPs – NGOs and Governments – to facilitate the transition from humanitarian to development
Is UNFPA currently providing support for developmental activities along with its support for humanitarian interventions? If yes, what are they? And in what ways do they provide a bridge to more development outcomes
What are the outstanding challenges/impediments to UNFPA support to more development outcomes?
Cross-cutting issues
How did your office integrate human rights approaches in the programming and implementation of the CP8 interventions?
What are the Monitoring and Evaluation strategies in place? Challenges and results?
What are innovations adopted in the CP8 interventions??
To what extent UNFPA has organized its interventions to maximize the HCT joint effects, e.g. with GBV programs of UNHCR and RH ones with UNICEF?

Recommendations
What should be the focus areas of the new/next UNFPA Country Programme in Rwanda?
What are your recommendations to government authorities and partners for strengthening and scaling up SRHR, gender / GBV, and population programmes to the national level?
RESOURCE MATERIALS
PLEASE PROVIDE ANY RESOURCE MATERIALS demonstrating the achievements of your programme: national strategies, policies, SOPs, and reports on training/workshops.

In-depth interview guides for implementation partners

Relevance: To what extent were the UNFPA country programme (2018 – 2024) and its four Outcomes relevant to the emergent needs of the target population(s) and adaptable to the changing humanitarian context in Rwanda? Was UNFPA able to respond and adapt its interventions to the changing humanitarian and development needs?
What are the services that you provide to your programme beneficiaries?
Or what type of support (financial, technical, in-kind, or capacity building) do you provide to implementing partners-IPs (or directly)?
How did you identify or prioritize the needs of your target population?
Did these needs or the urgency of these needs change over time (since 2018)? If yes, can you explain how? If not, can you explain why?
In your opinion, are these needs still outstanding now? To what extent and why?
To what extent are your interventions linked with national priorities and policies?
Did you adapt your program/services over time in response to a changing context or beneficiary needs? Please elaborate
Did you / UNFPA respond in a timely manner to IP requests for support to address the needs of the 'target populations'? Were delays encountered? If yes, what were the reasons? How can UNFPA enhance timely support in the future?
What are suggestions/recommendations to improve the relevance and adaptability of the UNFPA programme to the needs of the target population?

Effectiveness: a – To what extent did the UNFPA programme in Rwanda achieve planned programme outputs and is likely to contribute to programme outcomes in the area of:
Increased access to and utilization of quality reproductive health, including maternal health

services, for the target population in Rwanda;
What are the issues that your project has addressed (is still addressing) in the area of SRHR? How did your project address these issues? What did UNFPA support your work/project cover?
Were programme outputs achieved as planned in AWPs? If no, what were the challenges encountered and how did you address these challenges?
Was UNFPA support provided in a timely manner (in-kind, financial and technical)? Were delays encountered? Why? Did that affect project effectiveness?
Did UNFPA monitor the implementation of the project? How and how often? What did the monitoring activities cover?
Do you monitor the service delivery through the 'centres' in the refugee camps and or other regions? What are the 'issues' that you monitor (technical, staff, beneficiaries, records, implementation of protocols….?)
Did UNFPA provide technical assistance to your organization/programme staff? Training? If yes, what are the topics or in which areas?
Do you provide technical assistance and training to the project 'centres' and staff? In which topics or areas?
How many of the existing health facilities under your supervision have integrated youth-friendly services? What type of services is provided to the youth population? Have both girls and boys benefited from the services?
Do the delivery rooms comply with EmONC criteria, if not what are the shortages and challenges? How efficient UNFPA support has been to the facilities with delivery rooms?
What are the benefits/changes/**impact** that your project delivery is managing to achieve within the complex context of SRHR, FP, ANC, and PNC?
Can you provide concrete examples of changes in the personal lives of beneficiaries?
Community level changes /awareness perception of the problem? Community-level support to address the problem? Did you notice an increase in reported data?
Public advocacy, increased government commitment, laws, police, and research…?
Do you attend coordination meetings / working groups? In your opinion, to what extent did UNFPA contribute *"to enhanced capacities of government and civil society to deliver integrated high-quality reproductive health services that meet the needs of vulnerable populations"?*
In your opinion, to what extent did UNFPA support contribute to "increased access to and utilization of quality reproductive health, including maternal health services"?
How do you view the role played by UNFPA within the broader context of Integrated Reproductive Health actors? With the government of Rwanda/Ministry of Health?
What would be your suggestion/recommendations for enhanced effectiveness of UNFPA support in the area of SRHR + FP and capacity building of government and civil society?
Is the extent of needs still the same? Increasing? Decreasing with the returnee movement?
Effectiveness: b – Increased national capacity for the production of quality disaggregated data to inform policies and programs
Did UNFPA fund or support activities or interventions in the area of population dynamics (PD), research, and or technical capacity building of national government in PD for the past 3 years?
Who are UNFPA's main IPs (government directorates) for the Population Dynamics technical area?
What are these interventions? How were the needs for these interventions assessed? Why were they selected for implementation: i.e. what were the results/benefits to be generated from supporting or funding these interventions?
Were expected results achieved? How? Please elaborate and provide specific evidence.
Did UNFPA support the production of research? What type of research was supported during the emergency / humanitarian crisis and why? In what ways do they relate to the UNFPA mandate?
Did research results inform public policies? Which ones? Were these policies endorsed and applied?
Did UNFPA support in the PD area involve capacity building of national governments? If yes, in which technical areas? How were needs for capacity building assessed, and prioritized? Did UNFPA track, and assess the impact/results of the capacity-building interventions?
Did UNFPA interventions in the area of population dynamics improve national capacities in the production of quality disaggregated data? How and to what extent? Please elaborate and provide specific evidence.

Gender equality and human rights principles

To what extent did the implementation of the UNFPA programme in Rwanda take into account gender equality and human rights principles?
Are you aware of gender equality and human rights principles in programming? Did UNFPA train implementing partners on the integration of human rights principles and gender equality in their programs? Is UNFPA monitoring IPs for the integration of human rights principles and gender equality in their programming and service delivery to the target population?
Did IP programme design and implementation consider the social norms, roles, and responsibilities of women and men in the target population and the effects these may have had on their ability to fully access and participate in the program? How?
Were persons with disabilities, female or male, provided with equal access to services? Did they benefit from the programme equally? If so, how were persons with disabilities outreached? What provisions were made for them to join, and benefit from, the program? What more could have been done to ensure greater representation of persons with disabilities?
Were beneficiaries' opinions of the program/services provided ever assessed? What, If any, changes to the programme design or implementation were made as a result of this assessment?
Was there a system in place for beneficiaries to provide feedback on the program/services, anonymously or otherwise? What was this system? How did the programme respond to feedback? Can you give a specific example of when this system was used? How could it have been improved?
Did the programme /IP services cause any tensions within households or communities in any way? If yes, what were the causes for these tensions/ How were they addressed? What more could have been done to mitigate this tension? Please explain.
Was there a clear referral system in place for the referral of SGBV survivors? Was it known to all those involved? Were standard operating procedures clearly documented? Were codes of conduct regarding confidentiality and information-sharing adhered to by IP staff?
Did the programme have any unintended negative consequences for the target beneficiaries or the wider community? What were they? What effect did they have on those involved? What effect did they have on the program? How were negative consequences dealt with?
What factors contributed to unintended negative consequences? How could they have been mitigated?
Did the writing of the reports and other relevant documents consider structuring data or facts which are disaggregated by sex? Explain.
Efficiency: To what extent was UNFPA efficient in mobilizing resources – human, financial and technical – and securing partnerships for a timely response to emergent humanitarian needs?
Resource mobilization: Has the country office mobilized enough financial resources vis-à-vis what was needed to implement planned programme outputs? What was the rate of planned resources versus what was raised? If not, what can be done to improve CO resource mobilization strategies?
Did the country office devote the required human and technical resources for efficient programme implementation? For a timely disbursement of allocated funds? To support implementing partners in the technical areas of their programs? What were the challenges or impediments and how can they be addressed in future programs?
Were the institutional arrangements and operational mechanisms conducive to efficient operations in an emergency humanitarian context? In what ways? If not, what can be changed to enhance efficiency? Did the programme manage to secure the partnerships (NGOs and government) needed to respond to the emergent needs of the target population in a timely manner? To reach the geographical areas most in need of UNFPA assistance?
Did the programme manage a timely disbursement of funds to implementing partners to support the provision of services to the target populations? What were the challenges or impediments to a timely disbursement of funds and how can they be addressed in future programs?

Sustainability: To what extent did UNFPA humanitarian activities support or contribute to the transitioning towards longer-term (i.e., development and/or resilience-related) goals of the affected population?
What might be the intended and or unintended consequences of UNFPA ending its humanitarian

support to the affected population groups? How can they be mitigated?
How can UNFPA phase out its humanitarian interventions (in your area of work) towards more development objectives? What are 'activities' that can support a transition away from humanitarian towards developmental outcomes?
How can UNFPA build the capacities of IPs – NGOs and Governments – to facilitate the transition from humanitarian to development?
What should be the role and responsibilities of UNFPA in a more developmental context as compared to a humanitarian context?
Is UNFPA currently providing support for sustainable activities along with its support for humanitarian interventions? If yes, what are they? And in what ways do they provide a bridge to more development outcomes?
What are the outstanding challenges/impediments to UNFPA support to more development outcomes?

Effectiveness of the programme

What are the main successes and achievements of the 8th UNFPA Country Programme in Rwanda so far?
What were the main internal weaknesses of the programmes and what were the most important external challenges?
What was done by UNFPA Rwanda and what was done by partners to address those weaknesses or challenges?
Do you think that the CP is covering all the needs in your programme area? Are there any areas that should be reoriented or added to better address the needs and achieve results?

Coordination: a) To what extent was the UNFPA programme in Rwanda aligned with and contributing to the priorities of the wider humanitarian and development system as set out in the Rwanda UNSDCF, and UNFPA mandate and policies?
What were the mechanisms of coordination between different stakeholders to achieve tangible results of the SRHR and AY-related advocacy?
What are the main challenges of coordination especially in those clusters UNFPA leads?
b). To what extent has the country office contributed to the functioning and consolidation of UNCT and HCT coordination?

What is the role of UNFPA in UNCT and HCT coordination mechanisms?

To what extent has UNFPA organized its interventions to maximize the HCT joint effects?

Recommendations

What should be the focus areas of the new/next UNFPA Country Programme in Rwanda?
What are your recommendations to government authorities and partners for strengthening and scaling up SRHR, adolescents and youth, and population programmes to the national level?

FOCUS GROUP GUIDE – ADOLESCENTS AND YOUTH

Stakeholder target group: This interview will be carried out with youth and adolescents – beneficiaries of UNFPA-supported programs.
Please describe the activities that you attended / or benefitted from throughout your enrolment in this centre and or through this organization.
Do you come to this youth centre on a regular basis? How regular? Do you face challenges to visit the centre or to participate in its activities? If yes, what are these challenges and how do you address them?
How did you hear about this centre/organization's activities/programs? And what motivated you to participate/enrol i.e. what did you aim to learn, and achieve, what were your expectations when you enrolled?
Did you attend awareness training, training of trainers, or any other related awareness-raising activities? What were the subject matters – topics? Did you feel that these topics relate/respond to your own needs, life circumstances, or others? Please discuss and provide an example.
To what extent are this youth centre's programs responsive to the youth's needs/expectations, and or development outlook? What would be your suggestions and recommendations to improve the centre's

responsiveness to youth expectations?
How did you benefit? What did you gain? What did you learn? What changed in your life (attitudes, behaviour, outlook on life? As a result of participating in this centre's activities/program/training?
Are you overall satisfied with the services that you are receiving at this centre? Please elaborate.
How responsive are the centre's staff to your queries /problems/issues? Did they respond in a timely manner and to your satisfaction?
Did you contribute in any way to your community following your participation in this centre's activities or awareness-raising training? If yes, please describe how? (Did you provide training or awareness raising to others? Did you get engaged in a community committee or other?.....)
In your opinion what are the main challenges that youth are facing nowadays? In what ways can these challenges be addressed? Do you feel that this centre with UNFPA's support is addressing some of these challenges? What would you change or do differently?

INTERVIEW GUIDE – QUESTIONNAIRE – SEXUAL AND REPRODUCTIVE HEALTH
Stakeholder Target Group: This interview will be carried out with the managers/staff of the reproductive health facilities supported by UNFPA.

SRH Facility Name				
Location	(District)			
Type of location	IDP Camp	Refugee Camp	Host Community	Other
Field date:				

Interview Questions	
1.	What are the operation date/hours of the centre?
2.	Number of staff of the facility Gynaecologists Nurse General Practitioner Admin
3.	What type of SRHR services are you providing? Antenatal Care (ANC) Postnatal Care (PNC) Family Planning (FP) Delivery Curative Gender-Based Violence (GBV) including Clinical Management of Rape (CMR)
4.	When did UNFPA started supporting this clinic?
5.	What type of support are you receiving from UNFPA? Infrastructures Supplies (medical supplies, medical instruments and medication) Capacity Building Incentive for staff Other
6.	Do you receive supplies and medication in a timely manner? Please give an example
7.	Can you please describe data collection method?
8.	How many beneficiaries in the catchment areas as of now? Pregnant and lactating mothers Users of Contraception
9.	If there is delivery room? Does it comply with Emergency Obstetric and Newborn Care (EmONC)?
10.	What is the community perception of SRHR services especially Family Planning?
11.	Is there an integrated youth-friendly services? Please elaborate how the youth are reached and what type of services do you provide to youth?
12.	Have service providers been trained to provide adolescent-friendly services?
13.	Are there specific clinic times or spaces set aside for adolescents? If yes, please elaborate more.
14.	Do the following guidelines exists: SRHR Unit: Guidelines for Sexually transmitted infections (STIs), ANC, PNC, FP, CMR are available? Delivery Room: Guidelines for management of delivery, including complications, Referral guidelines, Occupational hazard policy, Health Care Waste Management, including for placenta?
15.	What are the training the core staff has taken before starting or during your work in the centre? Was Minimum initial service package (MISP) included? Has UNFPA support included training for staff? What type of training? Who provided it? What was the quality of the training? Did it improve staff effectiveness in service delivery?
16.	Is there any women centre providing SRHR awareness? If yes, how are you connected to them?

17.	Are referral mechanisms in place? (For medical emergencies, for mental health and psychological support, etc.) If yes, can you describe the procedure?
18.	How do you approach the targeted population for health awareness? What are the main challenges you are facing?
19.	Do you receive more or less demand for your services than you can supply? For which services? Please elaborate
20.	What are your most outstanding needs at the present time? Please explain why
21.	What are your recommendations moving forward?

Sexual and Reproductive Health Evaluation Tools – Beneficiary Survey
Stakeholder Target Group: Women Beneficiaries of SRHR Services.
This survey will be carried out with the women – beneficiaries of the SRHR facilities supported by UNFPA. The women will be selected randomly from the group of women who are present at the facility at the time of the evaluation field visit. Women will be invited to respond to the survey questions voluntarily, acceptance or refusal will be accepted regardless.
Introduction: The evaluator begins the survey by introducing themselves (name and organization – UNFPA) and the objective of the survey: "This survey is part of an overall evaluation process seeking to assess UNFPA support in reproductive health. The objective is organizational learning, accountability, and strategic decisions to inform the next programme cycle.

We would like to ask you some questions and are very interested to hear your opinion. If there is any question that you are not comfortable answering, please let us know. We will not ask you to share any sensitive personal information with us. The information you give us is completely anonymous, and we will not associate your name with anything you say during this meeting."

SRH Facility Name				
Organization managing the facility				
Location				
Type of location	IDP Camp	Refugee Camp	Host Community	Other
Filed date:				

SRHR Beneficiary Survey					
1.	Status	a-IDP	b. Refugee	c. Host community	
2.	Beneficiary age	(number of years)			
3.	Marital Status	a Single	b. married	c. widowed	d. divorced
4.	Sex		a Male	b. Female	
5.	How many pregnancies have you had?	(Number)			
6.	What is the spacing among the pregnancies	(Number: month or years)			
7.	Have you had pregnancies in the last two years?	a. Yes		b. No	
8.	Have you heard about any of the following?	ANC	a Yes	b. No	
		PNC	a Yes	b. No	
		FP	a Yes	b. No	
9.	How often have you visited the health centre/ any other SRHR related facility during your last pregnancy? Never	(number of times)			

	once			
10.	How do you access the following:			
	Access to the centre	a. very good	b. Satisfactory	c. Not good
11.	Time staff spent with you	a. very good	b. Satisfactory	c. Not good
12.	Privacy	a. very good	b. Satisfactory	c. Not good
13.	Staff experience	a. very good	b. Satisfactory	c. Not good
14.	Overall satisfaction with the services received	a. very good	b. Satisfactory	c. Not good
15.	Have you ever used any contraceptive methods	a. Yes	b. No	
16.	If no, why	a. I wanted to have a child		
		b. My husband or others in the family disapproved		
		c. Don't know how to use the contraceptives		
		d. Don't know where to get contraceptives		
		e. Cannot afford it		
		f. Others		
17.	Did the health provider ask which medical/preventive choice was best for you?	a. Yes	b. No	
18.	Have you ever participated in any awareness raising sessions?	a. Yes	b. No	
19.	If yes, how many	(number of times)		
20	What has this centre added to your knowledge or influenced your attitudes and practices about SRH and FP?			
21.	Do you have any suggestions on how the services in this facility can be improved?			

Sexual and Reproductive Health Evaluation Tools – Observation Checklist
Sexual and Reproductive Health Facilities

SRHR Facility Name				
Organization managing the facility				
Location				
Type of location	IDP Camp	Refugee Camp	Host Community	Other
Filed date:				

1- Facility grounds and buildings	a- Satisfactory	b- Medium	c- Poor
	- Is there a functioning and clean toilet for staff and beneficiaries?		

	- Is there adequate sitting and space for waiting patients?		
	- Do counselling and treatment rooms allow for privacy (both visual and auditory)?		
	- is the waiting area protected from rain and heat?		
2- Records, Reports	a- Satisfactory	b- Medium	c- Poor
	- ANC, PNC, FP log books and cards available and used		
	- Schedule for follow up visits is documented		
	- Pregnant women have visit record card		
3- Human Resource	a- Satisfactory	b- Medium	c- Poor
	-Available of health staff? How many and type		
4- Service delivery	a- Satisfactory	b- Medium	c- Poor
	- Access/ location of the centre		
	-Number of women attending the SRHR clinic at the time of the visit		
	Did the health worker display the following actions? Greeted the patient in a friendly manner Encouraged questions and listening well Ensured privacy		
5-Basic equipment/ Supplies SRHR	a- Satisfactory	b- Medium	c- Poor
	- Examination coach, - Privacy Curtains, - Fetal Heart Doppler, - Stethoscope, -Sphygmomanometer, - Weight Scale, - Step, - Clean sheet, - Urine strips, - Urine cups, - Tourniquet, Syringes, -Gloves, -Sharp Item container, -Hand disinfectant.		
6- Delivery Facility	a- Satisfactory	b- Medium	c- Poor
	- Obstetric delivery couch, -patient bed 2 section fixed, -baby bassinette mobile w shelf, -tape measurement plastic, -weighing scale hanging type for home delivery, -infant measuring rod (cradle measure), -infant scale non-digital.		
7-IEC material	a- Satisfactory	b- Medium	c- Poor
	Posters, Flip charts, Brochure/pamphlet counselling cards		
Any other observation:			

FOCUS GROUP GUIDE – ADOLESCENTS AND YOUTH

Stakeholder Target Group: This interview will be carried out with youth and adolescent – beneficiaries of UNFPA supported programs in recreational, vocational, and youth engagement. There will be the attendance list for each group specifying the sex, age, marital status. The interviewer will start with self-introduction and the explanation of the conditions and process of the discussion, and will ensure/negotiate the consent of participants.

Introduction: The focus group discussion is expected to take between 60 and 90 minutes and this guide is only a guiding tool for the discussions. To avoid overwhelming the participating beneficiaries with too many questions, the number of questions in this guide are kept at 10 or below. The moderator is expected to build on these questions with follow ups such as "can you come with an example of this behaviour", or "how did you deal with that" etc. Special focus should be given to include shy and quiet participants in the discussion. The moderator(s) will first present themselves to the participants and this will be followed by an introduction to the exercise:

Facilitator Name (s):

Name of Organization & Location of Centre:

Group and Size:

Location/District/Camp/Non-Camp:

Date:

Please describe the activities that you attended/ or benefitted from throughout your enrolment in this centre and or through this organization?

Do you come to this youth centre on a regular basis? How regular? Do you face challenges to visit the centre or to participate in its activities? If yes, what are these challenges and how do you address

them?
How did you hear about this centre/ organization' activities/programs? And what motivated you to participate/enrol i.e., what did you aim to learn, achieve, what were your expectations when you enrolled?
Did you attend awareness training, training of trainers or any other related awareness raising activities? What were the subject matters-topics? Did you feel that these topics relate/respond to your own needs, life circumstances or other? Please discuss, provide example
To what extent is this youth centre' programs responsive to the youth needs/expectations, and or development outlook? What would be your suggestions, recommendations to improve the centre's responsiveness to youth expectations?
How did you benefit? What did you gain? What did you learn? What changed in your life (attitudes, behaviour, outlook on life? As a result of participating in this centre activities/programs/training?
Are you overall satisfied of the services that you are receiving at this centre? Please elaborate.
How responsive are the centre's staff to your queries /problems / issues? Did they respond in a timely manner and to your satisfaction?
Did you contribute in any way to your community following your participation in this centre activities or awareness raising training? If yes, please describe how? (did you provide training or awareness raising to others? Did you get engaged in a community committee or other? …)
In your opinion what are the main challenges that youth are facing nowadays? In what ways can these challenges be addressed? Do you feel that this centre with UNFPA's support is addressing some of these challenges? What would you change or do differently?

Annex 5: List of UNFPA interventions

Interventions	*Sum of Project Budget (USD)*	*Sum of Budget Utilization (USD)*
Support SRH Policies	2,007,307	1,957,697.63
Support integrated SRH services	6,450,417.52	6,108,473.64
Support health workforce capacity	706,789.74	664,470.33
Support supply chain management	635,020.99	623,757.77
Support accountability for SRH	126,487	119,879.88
Support adolescent and youth skills and capabilities	2,008,681	1,866,938
Support youth policies	110,465	109,550
Support youth leadership and participation	112,351.7	106,598.23
Support accountability for gender equality	723.65	335.82
Support policy and accountability (2022–)	1,572,698.64	1,550,336.75
Support prevention and addressing of GBV	458,746.87	309,462.39
Support population data systems	1,954,105	1,929,785.71

Annex 6: CPE terms of reference

United Nations Population Fund (UNFPA) Rwanda 8th Country Programme Evaluation
(July 2018 – June 2024)

1. Introduction

The United Nations Population Fund (UNFPA) is the sexual and reproductive health United Nations agency that strives to deliver a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled. The strategic goal of UNFPA is to "achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the agenda of the Programme of Action of the International Conference on Population and Development (ICPD), to improve the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality."[90] In pursuit of this goal, UNFPA works towards three transformative and people-centred results: (i) end preventable maternal deaths; (ii) end the unmet need for family planning; and (iii) end gender-based violence (GBV) and all harmful practices, including female genital mutilation and child, early and forced marriage. These transformative results will contribute to the achievement of the Sustainable Development Goals (SDGs), in particular good health and well-being (Goal 3), the achievement of gender equality and the empowerment of women and girls (Goal 5), the reduction of inequality within and among countries (Goal 10), and peace, justice and strong institutions (Goal 16). In line with the vision of the 2030 Agenda for Sustainable Development, UNFPA seeks to ensure that no one is left behind and that the furthest behind are reached first.

UNFPA has been operating in Rwanda since 1969. The support that the UNFPA Rwanda Country Office (CO) provides to the Government of Rwanda under the framework of the 8th Country Programme (CP) (July 2018 – June 2024) builds on national development needs and priorities articulated in the 7 Years Government Programme: National Strategy for Transformation (NST I), 2017 – 2024, the Fourth Health Sector Strategic Plan (HSSP IV, July 2018 – June 2024), the United Nations Common Country Analysis (March 2021) and the United Nations Sustainable Development Cooperation Framework (UNSDCF, July 2018 – June 2024).

The 2019 UNFPA Evaluation Policy requires CPs to be evaluated at least every two programme cycles, "unless the quality of the previous country programme evaluation was unsatisfactory and/or significant changes in the country contexts have occurred."[91] The country programme evaluation (CPE) will provide an independent assessment of the relevance and performance of the UNFPA 8th CP (July 2018 to June 2024) in Rwanda, and offer an analysis of various facilitating and constraining factors influencing programme delivery and the achievement of intended results. The CPE will also draw conclusions and provide a set of actionable recommendations for the next programme cycle.

The evaluation will be implemented in line with the *Handbook on How to Design and Conduct a Country Programme Evaluation at UNFPA* (UNFPA Evaluation Handbook), which is available at https://www.unfpa.org/EvaluationHandbook. The Handbook provides practical guidance for managing and conducting CPEs to ensure the production of quality evaluations in line with the United Nations Evaluation Group (UNEG) norms and standards and international good practice for evaluation. It offers step-by-step guidance to prepare methodologically robust evaluations and sets out the roles and responsibilities of key stakeholders at all stages of the evaluation process. The Handbook includes a set of tools, resources and templates that provide practical guidance on specific activities and tasks that the evaluators and the evaluation manager perform during the different evaluation phases.

[90] UNFPA (2017). Strategic Plan 2018–2021, p. 3. https://www.unfpa.org/sites/default/files/resource-pdf/DP.FPA_.2017.9_-_UNFPA_strategic_plan_2018–2021_-_FINAL_-_25July2017_-_corrected_24Aug17.pdf.
[91] UNFPA (2019). Evaluation Policy 2019, p. 20. https://www.unfpa.org/admin-resource/unfpa-evaluation-policy–2019.

The main audience and primary intended users of the evaluation are: (i) The UNFPA Rwanda CO; (ii) the Government of Rwanda; (iii) implementing partners of the UNFPA Rwanda CO; (iv) rights-holders involved in UNFPA interventions and the organizations that represent them (in particular: women, adolescents, and youth); (v) the United Nations Country Team (UNCT); (vi) East and Southern Africa Regional Office (ESARO); and (vii) donors. The evaluation results will also be of interest to a wider group of stakeholders, including: (i) UNFPA headquarters divisions, branches, and offices; (ii) the UNFPA Executive Board; (iii) academia; and (iv) local civil society organizations and international NGOs. The evaluation results will be disseminated as appropriate, using traditional and digital channels of communication.

The evaluation will be managed by the evaluation manager within the UNFPA Rwanda CO, with guidance and support from the regional monitoring and evaluation (M&E) adviser at the ESARO, and in consultation with the evaluation reference group (ERG) throughout the evaluation process. A team of independent external evaluators will conduct the evaluation and prepare an evaluation report in conformity with these terms of terms of reference.

2. Country Context

Demographic situation: According to the recently published population census, Rwanda counts 13.2 million total population in 2022[92]; the total fertility rate is 3.6 births per woman and the annual growth rate is 2.3 per cent. Rwanda has a youthful population, with 65.3 per cent under age 30 and 56 per cent between the ages of 16 and 64 in 2022. Rwanda has the opportunity to reap a demographic dividend and to attain its vision of becoming a middle-income country by 2035 and high-income country, as outlined in the Vision 2050 framework. In the National Strategy for Transformation (2017–2024), the Government committed to harness the demographic dividend by ensuring access to high-quality health and education for all. The country is densely populated, with a population density of around 503[93] people per square kilometre. The majority of the population lives in rural areas (72.1), with agriculture being the primary source of income.

Rwanda has experienced a significant population growth rate over the past few decades, with an average annual rate of population change of 2.3% between 2012 and 2022. This growth rate has slowed down in recent years, and the country is projected to have a population of around 23.5 million people by 2052 according to the 2022 population and housing census. In terms of age distribution, Rwanda has a relatively young population. The proportion of the population per age group is as follows: the proportion of young people (below 30 years) dropped from 70.3% in 2012 to 65.3% in 2022 and is expected to be 54.3% by 2050 while those aged between 16- and 64-years old increased from 53.4% in 2012 to 56.0% in 2022, and is expected to be 61.4% by 2050. People over the age of 65 represent a small proportion of the population, at around 4.2%.

Economic situation: Rwanda is a landlocked country located in East Africa. Over the past decade, the country made significant strides in its economic development. The country's average household income is estimated to be around $816 as of 2020[94], which is considered a low-income country. However, Rwanda's economy has been growing at a steady pace, with an average growth rate of 8% over the past decade. Over the past two decades, the national gross domestic product has grown at an average annual rate of 7.3 per cent between 2002 and 2021[95]. This economic growth led to a significant decline in poverty rates, down from 58.9 per cent in 2001 to 38.2[96] per cent in 2017.

[92] National Institute of Statistics of Rwanda (NISR) (2023). The Fifth Rwanda Population and Housing Census, Main Indicators Report. Kigali: NISR

[93] Ibid.

[94] Rwanda Ministry of Finance and Economic Planning (MINECOFIN) (2021). Key statistics on Rwanda, 2020. https://www.minecofin.gov.rw/index.php?eID=dumpFile&t=f&f=24255&token=fe3608ba115430a0878f9a7ce493f8f9e1c45507

[95] NISR National Account (calculated average GDP growth rate 2002–2021)

[96] National Institute of Statistics of Rwanda (NISR) (2018). Fifth Integrated household Living Conditions Survey –

Inequality has been reduced (the Gini coefficient fell from 0.55 to 0.43.7 by 2016[97]), although the unemployment rate among young people (aged 16–24 years) has fluctuated from 17.3% (February 2020) to 30.9% (May 2021), then 22.8% (February 2022) and 32.0% (November 2022).[98]
The country has also made progress in reducing poverty. According to the World Bank, the percentage of the population living below the poverty line has decreased from 56.7% in 2006 to 38.2% in 2017. However, poverty remains a significant challenge, particularly in rural areas, where the poverty rate is higher. The Human Development Index (HDI) is a measure of the quality of life in a country, which considers factors such as education, healthcare, and income. Rwanda's HDI score was 0.524 as of 2017[99], which is considered low. However, the country has made significant progress in improving its HDI over the past decade, with an average annual increase of 1.88%. Despite this, Rwanda has implemented policies aimed at reducing inequality, such as increasing access to education and healthcare for all citizens.
Maternal/child health: [100] Maternal mortality ratio in Rwanda is 203 per 100,000 live births and 98.5% of births occurred in health facilities (HMIS). In Rwanda, 5.2% of women aged 15–19 have begun childbearing; 4% have given birth, and 1% are pregnant with their first child (DHS 2019–20). Under-5 child mortality rate as per the RDHS 2019–2020 declined from 196 deaths per 1,000 live births in 2000 to 45 deaths in 2019–20; while still implying that 1 in 22 children in Rwanda die before their 5th birthday. Ninety-eight per cent (98%) of women aged 15–49 who gave birth in the 5 years preceding the RDHS 2019–20 received antenatal care (ANC) from a skilled provider during the pregnancy for their most recent birth. Forty-seven (47%) had at least four ANC visits (DHS 2019–2020). While 70% of women who gave birth in the 2 years preceding the RDHS 2019–2020 received a postnatal check in the first 2 days after birth; 75% of infants received a postnatal check in the first 2 days after birth.

Since 2005, HIV prevalence has remained at three per cent in the general population, although it differs significantly among sub-populations; the most affected are key populations such as female sex workers with the prevalence rate at 35%[101] and men having sex with men (MSM) at 4%. New HIV infections have declined from 27 to 8 per 10,000 population (DHS 2019–20).

According to the RDHS 2019–20, only 1% of women aged 15–49 reported having two or more sexual partners in the past 12 months. In the 12 months before the same survey, 9% of women reported having sexual intercourse with a person who neither was their husband nor lived with them, and fewer than half of those women (46%) reported using a condom during the last sexual intercourse with such a partner. Among men aged 15–49, 6% reported having two or more sexual partners in the 12 months before the survey, and 12% reported having sexual intercourse with a person who neither was their wife nor lived with them. Seventy per cent of those men reported using a condom during the last sexual intercourse with such a partner. Since 2016, Comprehensive Sexuality Education (CSE) has officially been integrated in primary and secondary education nationwide and – at secondary level – can be found in General Studies, Biology and Health Sciences, Communication Skills, History and Citizenship classes (Rwanda Education Board). The tendency to initiate sexual intercourse before age 15 is higher among men than women (10.1% versus 4.5%, RDHS 2019–20). The percentage of women with comprehensive knowledge about HIV varies by age, from 54% among those aged 15–19 to 69% among those aged 40–49. The percentage of men with comprehensive knowledge increases from 55% among those aged 15–19 to 70% among those aged 30–39 before dropping to 66% among those aged 40–49 (DHS 2019–20).

Main Indicators Report 2016/17 (EICV5). https://www.statistics.gov.rw/publication/eicv-5-main-indicators-report-201617
[97] The 2016 World Bank Gini Index for Rwanda: https://data.worldbank.org/indicator/SI.POV.GINI?locations=RW
[98] Labor force survey, of November and February 2022
[99] UNDP Human Development Index, 2021
[100] All data from National Institute of Statistics of Rwanda (NISR), Ministry of Health (MOH), and ICF (2020). Rwanda Demographic and Health Survey 2019–20. Key Indicators Report. Kigali, Rwanda, and Rockville, Maryland, USA: NISR and ICF.
[101] Assessment of HIV services delivery to key populations in Rwanda (May 2022, Rwanda Biomedical Centre and UNFPA)

The contraceptive prevalence rate is 64% among currently married women aged 15–49. Most currently married women using contraception use a modern method (58%), while 6% use a traditional method. Fifty per cent of sexually active unmarried women use a contraceptive method, with 48% using a modern method and 2% using a traditional method. However, 14% of currently married women aged 15–49 have an unmet need for family planning (7% each for limiting and for spacing); the unmet need consistently decreased over time, from 39% in 2005 to 14% in 2019–20. Regarding modern contraceptive methods, implants and injectables are the most commonly used among both currently married women (27% and 15%, respectively) and sexually active unmarried women (22% and 15%, respectively). Only a small proportion of currently married women who do not have a child use a modern contraceptive method (3%). Among women with children, modern contraceptive use is higher among those with three or four children (66%) than among those with one or two children (62%) and those with five or more children (52%) (DHS 2019–20). By province, modern contraceptive use among currently married women ranges from 54% in West to 65% in North.

Among women aged 15–49, 37% have experienced physical violence since the age of 15 and 23% of women aged 15–49 have ever experienced sexual violence. The corresponding proportions among men are 30% and 6%. Nearly sixty-five per cent (64.9%) of women aged 15–49 agree that a husband is justified in hitting or beating his wife (DHS 2019–20); 38.5% for the male counterpart.

The National Institute of Statistics of Rwanda (NISR) increased its capacity consistently, and in 2022, successfully conducted the 5th Rwanda Population and Housing Census - the first-ever digital census in Rwanda - to update the demographic data and inform planning, policy formulation, implementation, and monitoring of interventions in development and humanitarian settings. The Census questionnaire introduced questions regarding people with disabilities to leave no one behind and used digital devices for data collection that mitigated the constraints caused by impact of the COVID-19 enabling real-time rapid data analysis.
Man-made and/or natural disasters: Rwanda has experienced several man-made and natural disasters throughout its history, which have had significant effects on the health, well-being, safety, and security of its population, including women, adolescents, and youth. One of the most devastating man-made disasters in Rwanda was the genocide against the Tutsi of 1994, in which an estimated one million people, killed over a period of 100 days. The genocide had a significant impact on women, adolescents, and youth, who were subjected to sexual violence, forced displacement, and other forms of abuse. The trauma of the genocide has had long-lasting effects on the mental health and well-being of survivors, particularly women and children. Rwanda is also prone to natural disasters, such as droughts, earthquakes, volcanoes, storms, and floods. A total of 28,413 floods were recorded from 2019 to 2020[102]; leading to displacement and loss of livelihoods, particularly among vulnerable populations as women, adolescents and youth, for instance the one from 07 to 09 May 2020, approximately 16,210 people (3,242 households) were affected by the heavy rainfalls and flooding across the districts of Gakenke, Ngororero, Nyabihu and Rubavu[103].

Rwanda has been hosting refugees for over two decades, as a party to the 1951 Refugee Convention and its 1967 Protocol. As of March 2023, a total of 126,429 people of concern are being hosted in Rwanda: 75,041 (59.4%) had the origin of the Democratic Republic of Congo, followed by 50,596 (40.0%) from Burundi, 407 (0.3%) from others, and 385 (0.3%) from Eritrea.[104] The Congolese refugees include people who fled in the 1990s, as well as more recent arrivals who fled to Rwanda

[102] World Bank Group Climate Change Knowledge Portal for Development Practitioners and Policy Makers, Country Profile Rwanda: https://climateknowledgeportal.worldbank.org/country/rwanda/vulnerability
[103] International Federation of Red Cross and Red Crescent Societies (2021). Rwanda: Floods and Windstorm - Final Report (MDRRW019).
https://reliefweb.int/report/rwanda/rwanda-floods-and-windstorm-final-report-mdrrw019#:~:text=Description%20of%20the%20disaster&text=Between%2007%20and%2009%20May,disasters%20across%20the%20four%20districts
[104] UNHCR Rwanda.
https://data.unhcr.org/en/country/rwa#_ga=2.62078564.917109350.1682346085-1515518718.1644500851

during the 2012–2013 renewed hostilities in eastern DRC; and concerning Burundian refugees, Rwanda opened its border to host thousands of Burundian refugees who have fled the country due to the election-related tensions since April 2015. Additionally, Rwanda hosts small numbers of refugees from other countries such as Eritrea, South Sudan, Sudan, Somalia and Ethiopia representing 0.6% per cent of the total refugee population as of March 2023. Rwanda has 5 refugee camps across the country, namely Mahama camp (that hosts 46.5% of the refugee population), Kiziba camp (12.6%), Kigeme camp (11.7%), Nyabiheke camp (10.4%), and Mugombwa camp (9.2%).

3. UNFPA Country Programme

UNFPA has been working with the Government of Rwanda since 1969 towards enhancing sexual and reproductive health and rights (SRHR), advancing gender equality, realizing rights and choices for young people, and strengthening the generation and use of population data for development. UNFPA is currently implementing the 8th CP in Rwanda.

The 8th CP (July 2018 – June 2024) is aligned with NST 1 (2017–2024), HSSP IV (July 2018-June 2024), UNSDCF (July 2018-June 2024), and UNFPA strategic plans (2018–2021; 2022–2025). In 2022, the UNFPA Rwanda CO undertook the process of aligning the 8th CP to the UNFPA Strategic Plan 2022–2025 as well as to the UNSDCF; this was subsequent to the transition from the United Nations Development Assistance Plan (UNDAP) to the UNSDCF through the light alignment. The 8th CP was developed in consultation with the Government, civil society, bilateral and multilateral development partners, including United Nations organizations, and academia.

The UNFPA Rwanda CO delivers its CP through the following modes of engagement: (i) advocacy and policy dialogue, (ii) capacity development, (iii) knowledge management, (iv) partnerships and coordination, and (v) service delivery. The overall goal of the UNFPA Rwanda 8th CP (July 2018 – June 2024) is universal access to sexual and reproductive health and reproductive rights and reduced maternal mortality, as articulated in the UNFPA Strategic Plans 2018–2021 and 2022–2025. The CP contributes to the following outcomes of the UNFPA Strategic Plan 2018–2021 and 2022–2025:

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

The UNFPA Rwanda 8th CP (July 2018 – June 2024) has 3 thematic areas of programming with distinct outputs that are structured according to the 4 outcomes in the Strategic Plan 2018–2021 to which they contribute.

Outcome 1: Sexual and reproductive health and rights

Output 1. National and subnational institutions have enhanced capacities to develop and implement strategies, guidelines and standards for increased access to information and services on sexual and reproductive health and reproductive rights. This has been delivered through:

- Supporting National and district-level financial sustainability plans for family-planning services.
- Supporting the availability of updated guidelines on adolescent sexual reproductive health, family planning, maternal, neonatal and child health, HIV/STIs and gender-based violence available and their dissemination.

- Facilitating the development and capacity building of midwifery schools using a standardized competency-based academic curriculum.

Output 2. National and subnational institutions have enhanced capacities to effectively deliver integrated, youth-friendly SRH services, including to key populations and in humanitarian situations. This has been delivered through:

- Facilitation on the availability of equipment in service delivery points.
- Capacity development of health centres in the target districts to provide youth-friendly services as per national standards.
- Supporting accessibility of sexual and reproductive health and HIV services in target districts such as Rusizi, Nyamasheke and Karongi districts to female sex workers
- Providing refugee camps with adolescent SRH services.

Outcome 2: Adolescents and youth

Output 1. Young people, especially young girls, are equipped with knowledge and skills to make informed decisions on reproductive health and reproductive rights and to fully participate in development and humanitarian actions. This has been delivered through:

- Providing youth-lead organizations and networks with capacity to participate in national sexual and reproductive health-related policy dialogue, advocacy, and programming, including in humanitarian settings.
- Supporting the establishment of partnerships for piloting and transitioning-to-scale of innovations in adolescent sexual and reproductive health.
- Providing support to public and private schools implementing comprehensive sexuality education, according to the national education curricula.

Outcome 4: Population dynamics

Output 1. Government institutions at national and subnational levels are better able to generate and use disaggregated data to inform policies and programmes that address inequalities in development and humanitarian settings. This has been delivered through:

- Providing support to conduct and disseminate the RDHS reports.
- Facilitating integration of UNFPA priority SDG indicators into population-based surveys and national data collection systems
- Facilitating integration of the demographic dividend study recommendations into the national development frameworks
- Support NISR to conduct the 5th Population and Housing Census

The UNFPA Rwanda CO also takes part in activities of the UNCT, with the objective to ensure inter-agency coordination and the efficient and effective delivery of tangible results in support of the national development agenda and the SDGs. In the context of Rwanda, Refugee Coordination Meeting exists, chaired by the Ministry in charge of Emergency Management (MINEMA) and UNHCR, whereby sector coordination meetings (health; and protection) happen. UNFPA CO participates in the Refugee Coordination Meeting. Due to the protracted situation of the refugee settings, Rwanda is not applicable for the evaluation regarding humanitarian support as per the CPE guidance.

The theory of change that describes how and why the set of activities planned under the CP are expected to contribute to a sequence of results that culminates in the strategic goal of UNFPA is presented in Annex A. The 8th CP theory of change was reconstructed to include both UNFPA SPs 2018–2021 and 2022–2025, changes in business model and modes of engagement, as well as the UNSDCF that was revised from UNDAP in 2021. The theory of change will be an essential building block of the evaluation methodology. The CP theory of change to explains how the activities undertaken contribute to a chain of results that lead to the intended or observed outcomes. At the design phase, the evaluators will perform an in-depth review of the CP theory of change This will help them refine the evaluation questions (see preliminary questions in section 5.2), identify key

indicators for the evaluation, plan data collection (and identify potential gaps in available data), and provide a structure for data collection (the evaluation matrix – see section 6.2 and Annex C) analysis and reporting. The evaluators' review of the theory of change (its validity and comprehensiveness) is also crucial with a view to informing the preparation of the next country programme's theory of change by the BP.

The UNFPA Rwanda 8th CP (July 2018 – June 2024) is based on the following results framework presented below:

Rwanda/UNFPA 8th Country Programme (July 2018 – June 2024) Results Framework

Goal: Achieved universal access to sexual and reproductive health, realized reproductive rights, and reduced maternal mortality to accelerate progress on the ICPD agenda, to improve the lives of adolescents, youth and women, enabled by population dynamics, human rights, and gender equality				
UNFPA Thematic Areas of Programming				
I. Sexual Reproductive Health and Rights		II. Adolescents and Youth		III. Population Dynamics
UNFPA Strategic Plan Outcomes				
Outcome 1. Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated SRH services and exercised reproductive rights, free of coercion, discrimination and violence		Outcome 2: Every adolescent and youth, in particular adolescent girls, is empowered to have access to sexual and reproductive health and reproductive rights, in all contexts		Outcome 4: Everyone, everywhere, is counted, and accounted for, in the pursuit of sustainable development.
UNFPA Rwanda 8th CP Outputs				
Output 1. National and subnational institutions have enhanced capacities to develop and implement strategies, guidelines and standards for increased access to information and services on sexual and reproductive health and reproductive rights. Output 2. National and subnational institutions have enhanced capacities to effectively deliver integrated, youth-friendly SRH services, including for key populations and in humanitarian situations.		Output 1. Young people, especially young girls, are equipped with knowledge and skills to make informed decisions on reproductive health and reproductive rights and to fully participate in development and humanitarian actions.		Output 1. Government institutions at national and subnational levels are better able to generate and use disaggregated data to inform policies and programmes that address inequalities in development and humanitarian settings.
UNFPA Rwanda 8th CP Intervention Areas				

• Support National and district-level financial sustainability plans for family-planning services. • Support the availability of updated guidelines on adolescent sexual reproductive health, family planning, maternal, neonatal and child health, HIV/STIs and gender-based violence available and their dissemination. • Facilitate the development and capacity building of midwifery schools using a standardized competency-based academic curriculum. • Facilitation on the availability of equipment in service delivery points. • Capacity development of health centres in the target districts to provide youth-friendly services as per national standards. • Supporting accessibility of sexual and reproductive health and HIV services in target districts such as Rusizi, Nyamasheke and Karongi districts to female sex workers • Providing refugee camps with adolescent SRH services.	• Providing youth-lead organizations and networks with capacity to participate in national sexual and reproductive health-related policy dialogue, advocacy, and programming, including in humanitarian settings. • Supporting the establishment of partnerships for piloting and transitioning-to-scale of innovations in adolescent sexual and reproductive health. • Providing support to public and private schools implementing comprehensive sexuality education, according to the national education curricula.	• Providing support to conduct and disseminate the RDHS reports. • Facilitating integration of UNFPA priority SDG indicators into population-based surveys and national data collection systems • Facilitating integration of the demographic dividend study recommendations into the national development frameworks • Support NISR to conduct the 5th Population and Housing Census

4. Evaluation Purpose, Objectives and Scope

4.1. Purpose

The CPE will serve the following three main purposes, as outlined in the 2019 UNFPA Evaluation Policy: (i) demonstrate accountability to stakeholders on performance in achieving development results and on invested resources; (ii) support evidence-based decision-making; and (iii) contribute key lessons learned to the existing knowledge based on how to accelerate the implementation of the Programme of Action of the 1994 ICPD.

4.2. Objectives

The objectives of this CPE are:

1. To provide the UNFPA Rwanda CO, national stakeholders, and rights-holders, the UNFPA ESARO, UNFPA Headquarters as well as a wider audience with an independent assessment of the UNFPA Rwanda 8th CP (July 2018 – June 2024).
2. To broaden the evidence-base to position UNFPA within the updating of the United Nations ASRH and the development of the UNSDCF, as well as inform the design of the next programme cycle guided by the new UNSDCF.

The specific objectives of this CPE are:

i. To provide an independent assessment of the relevance, effectiveness, efficiency, and sustainability of UNFPA support.
ii. To provide an assessment of the role played by the UNFPA Rwanda CO in the coordination mechanisms of the UNCT, with a view to enhancing the United Nations collective contribution to national development results.
iii. To draw key conclusions from past and current cooperation and provide a set of clear, forward-looking, and actionable recommendations for the next programme cycle.

4.3. Scope

Geographic Scope

The evaluation will cover the following districts where UNFPA implemented interventions: Karongi, Nyamasheke, and Rusizi, in addition to the nation-wide support.

Thematic Scope

The evaluation will cover the following thematic areas of the 8th CP: Sexual and reproductive health and rights; adolescents and youth, and population dynamics. In addition, the evaluation will cover cross-cutting issues, such as human rights; gender equality; disability, and transversal functions, such as coordination; monitoring and evaluation (M&E); innovation; resource mobilization; strategic partnerships.

Temporal Scope

The evaluation will cover interventions planned and/or implemented within the time period of the current CP: July 2018 – June 2024.

5. Evaluation Criteria and Preliminary Evaluation Questions

5.1. Evaluation Criteria

In accordance with the methodology for CPEs outlined in the UNFPA Evaluation Handbook (see section 3.2, pp. 51–61), the evaluation will examine the following four OECD/DAC evaluation criteria: relevance, effectiveness, efficiency and sustainability.[105] It will also use the evaluation criterion of coordination to assess the extent to which the UNFPA Rwanda CO harmonized interventions with other actors, promoted synergy and avoided duplication under the framework of the UNCT.

[105] The full set of OECD/DAC evaluation criteria, their adapted definitions and principles of use are available at: https://www.oecd.org/dac/evaluation/revised-evaluation-criteria-dec–2019.pdf.

Relevance	The extent to which the objectives of the UNFPA country programme correspond to population needs at country level (in particular, those of vulnerable groups), and were aligned throughout the programme period with government priorities and with strategies of UNFPA.
Effectiveness	The extent to which country programme outputs have been achieved and the extent to which these outputs have contributed to the achievement of the country programme outcomes.
Efficiency	The extent to which country programme outputs and outcomes have been achieved with the appropriate number of resources (funds, expertise, time, administrative costs, etc.).
Sustainability	The continuation of benefits from a UNFPA-financed intervention after its termination, linked, in particular, to their continued resilience to risks.
Coordination	The extent to which UNFPA has been an active member of and contributor to existing coordination mechanisms of the UNCT. This also includes UNFPA membership of, and contributions to humanitarian coordination mechanisms of the HCT, where applicable.
Connectedness	The extent to which activities of a short-term emergency nature are carried out in a context that takes longer-term and interconnected problems into account.

5.2. Preliminary Evaluation Questions

The evaluation of the CP will provide answers to the evaluation questions (related to the above criteria), which determine the thematic scope of the CPE.

The evaluation questions presented below are indicative and preliminary. Based on these examples, the country office staff in collaboration with relevant stakeholders is expected to develop a set of questions directly relevant to the CP under evaluation and insert them in this section. At the design phase, the evaluators are expected to develop a final set of evaluation questions, in consultation with the evaluation manager at the UNFPA Rwanda CO and the ERG. The questions to be used to evaluate the UNFPA Rwanda country programme in relation to each OECD/DAC criteria include:

1. Relevance:

To what extent does the UNFPA Rwanda 8th Country Programme align with (i) Rwanda's development priorities and (ii) UNFPA's global strategic plans; and (iii) the needs of the intended beneficiaries, namely women, young people, and vulnerable populations including people with disabilities and key populations? (iv) To what extent has the programme remained relevant and responsive to changing circumstances and varied needs of the population? Were there any unintended consequences or negative impacts on the intended and/or unintended beneficiaries or other stakeholders, and how were they addressed?

2. Effectiveness:

To what extent has the 8th CP contributed to (i) increasing access and use of integrated SRH services; (ii) increasing knowledge and skills in young people, particularly girls' to make informed decisions about SRHR and fully participate in development and humanitarian actions; (iii) and enhancing generation and use of disaggregated data to inform policies and programmes? (iv) To what extent has UNFPA successfully integrated human rights, gender perspectives and disability inclusion in the country programme?

3. Efficiency:

To what extent has UNFPA made good use of its human, time, financial and technical resources to pursue the achievement of the outcomes defined in the county programme? Were the programme activities and outputs produced in a cost- and time- efficient and quality manner?

4. Sustainability:

To what extent has UNFPA been able to support implementing partners and rights-holders (notably, women, adolescents and youth) in developing capacities and establishing mechanisms to ensure the durability of effects?

5. Coordination:
To what extent has UNFPA contributed to the functioning and consolidation of the coordination mechanisms with other development stakeholders including the government, civil society, development partners, and UNCT for the development of Rwanda? To what extent has the UNFPA Rwanda Country Programme created synergies with other development programs and policies in Rwanda, to amplify results of the national agenda?

6. Connectedness (related to humanitarian):
To what extent has UNFPA contributed to developing the capacity of local and national actors (government line ministries, youth and women's organizations, health facilities, communities, etc.) to better prepare for and respond to the refugee situations?

The final evaluation questions and the evaluation matrix will be presented in the design report.

6. Approach and Methodology

6.1. Evaluation Approach

Theory-based approach
The CPE will adopt a theory-based approach that relies on an explicit theory of change which depicts how the interventions supported by the UNFPA Rwanda CO are expected to contribute to a series of results (outputs and outcomes) that contribute to the overall goal of UNFPA. The theory of change also identifies the causal links between the results, as well as critical assumptions and contextual factors that support or hinder the achievement of desired changes. A theory-based approach is fundamental for generating insights about what works, what does not and why. It focuses on the analysis of causal links between changes at different levels of the results chain that the theory of change describes, by exploring how the assumptions behind these causal links and contextual factors affect the achievement of intended results.
The theory of change will play a central role throughout the evaluation process, from the design and data collection to the analysis and identification of findings, as well as the articulation of conclusions and recommendations. The evaluation team will be required to verify the theory of change underpinning the UNFPA Rwanda 8th CP (July 2018 – June 2024) (see Annex A) and use this theory of change to determine whether changes at output and outcome levels occurred (or not) and whether assumptions about change hold true. The analysis of the theory of change will serve as the basis for the evaluators to assess how relevant, effective, efficient and sustainable the support provided by the UNFPA Rwanda CO was during the period of the 8th CP.

As part of the theory-based approach, the evaluators shall use a contribution analysis to explore whether evidence to support key assumptions exists, examine if evidence on observed results confirms the chain of expected results in the theory of change, and seek out evidence on the influence that other factors may have had in achieving desired results. This will enable the evaluation team to make a reasonable case about the difference that the UNFPA Rwanda 8th CP (July 2018 – June 2024) made.

Participatory approach
The CPE will be based on an inclusive, transparent, and participatory approach, involving a broad range of partners and stakeholders at national and sub-national levels. The UNFPA Rwanda CO has developed an initial stakeholder map (see Annex B) to identify stakeholders who have been involved in the preparation and implementation of the CP, and those partners who do not work directly with UNFPA yet play a key role in a relevant outcome or thematic area in the national context. These stakeholders include government institutions, civil society organizations, implementing partners, academia, other United Nations organizations, donors and, most importantly, rights-holders (notably women, adolescents and youth). They can provide information and data that the evaluators should use to assess the contribution of UNFPA support to changes in each thematic area of the CP. Particular

attention will be paid to ensuring participation of women, adolescents and young people, especially those from vulnerable and marginalized groups (e.g., young people and women with disabilities, etc.).

The evaluation manager in the UNFPA Rwanda CO has established an ERG comprised of key stakeholders of the CP, including Governmental and non-governmental counterparts at national level, including organizations representing persons with disabilities, the regional M&E adviser in UNFPA ESARO. The ERG will provide inputs at different stages in the evaluation process.

Mixed-method approach
The evaluation will primarily use qualitative methods for data collection, including document review, interviews, group discussions and observations during field visits, where appropriate. The qualitative data will be complemented with quantitative data to minimize bias and strengthen the validity of findings. Quantitative data will be compiled through desk review of documents, websites and online databases to obtain relevant financial data and data on key indicators that measure change at output and outcome levels.

These complementary approaches described above will be used to ensure that the evaluation: (i) responds to the information needs of users and the intended use of the evaluation results; (ii) upholds human rights and principles throughout the evaluation process, including through participation and consultation of key stakeholders (rights holders and duty bearers); and (iii) provides credible information about the benefits for duty bearers and rights-holders (women, adolescents and youth) of UNFPA support through triangulation of collected data.

6.2. Methodology

The evaluation team shall develop the evaluation methodology in line with the evaluation approach and guidance provided in the UNFPA Evaluation Handbook. The Handbook will help the evaluators develop a methodology that meets good quality standards for evaluation at UNFPA and the professional evaluation standards of UNEG. It is expected that, once contracted by the UNFPA Rwanda CO, the evaluators acquire a solid knowledge of the Handbook and the proposed methodology of UNFPA.

The CPE will be conducted in accordance with the UNEG *Norms and Standards for Evaluation*,[106] *Ethical Guidelines for Evaluation*,[107] *Code of Conduct for Evaluation in the United Nations System*[108], *and Guidance on Integrating Human Rights and Gender Equality in Evaluations.*[109] When contracted by the UNFPA Rwanda CO, the evaluators will be requested to sign the UNEG *Code of Conduct*[110] prior to starting their work.

The methodology that the evaluation team will develop builds the foundation for providing valid and evidence-based answers to the evaluation questions and for offering a robust and credible assessment of UNFPA support in Rwanda. The methodological design of the evaluation shall include in particular: (i) a theory of change; (ii) a strategy for collecting and analysing data; (iii) specifically designed tools for data collection and analysis; (iv) an evaluation matrix; and (v) a detailed evaluation work plan and agenda for the field phase.

The evaluation team is strongly encouraged to refer to the Handbook throughout the whole evaluation process and use the provided tools and templates for the conduct of the evaluation.

The evaluation matrix
The evaluation matrix is centrepiece to the methodological design of the evaluation (see Handbook, section 1.3.1, pp. 30–31 and Tool 1: The Evaluation Matrix, pp. 138–160 as well as the evaluation matrix template in Annex C). The matrix contains the core elements of the evaluation. It outlines (i)

[106] Document available at: http://www.unevaluation.org/document/detail/1914.
[107] Document available at: http://www.unevaluation.org/document/detail/102.
[108] Document available at: http://www.unevaluation.org/document/detail/100.
[109] Document available at: http://www.unevaluation.org/document/detail/980.
[110] UNEG Code of conduct: http://www.unevaluation.org/document/detail/100.

what will be evaluated: evaluation questions for all evaluation criteria and key assumptions to be examined; and (ii) *how it will be evaluated*: data collection methods and tools and sources of information for each evaluation question and associated key assumptions. By linking each evaluation question (and associated assumptions) with the specific data sources and data collection methods required to answer the question, the evaluation matrix plays a crucial role before, during and after data collection.

- In the design phase, the evaluators should use the evaluation matrix to develop a detailed agenda for data collection and analysis and to prepare the structure of interviews, group discussions and site visits. At the design phase, the evaluation team must enter, in the matrix, the data and information resulting from their desk (documentary review) in a clear and orderly manner.
- During the field phase, the evaluation matrix serves as a working document to ensure that the data and information are systematically collected (for each evaluation question) and are presented in an organized manner. Throughout the field phase, the evaluators must enter, in the matrix, all data and information collected. The evaluation manager will ensure that the matrix is placed in a Google drive and will check the evaluation matrix on a daily basis to ensure that data and information is properly compiled. S/he will alert the evaluation team in the event of gaps that require additional data collection or if the data/information entered in the matrix is insufficiently clear/precise.
- In the reporting phase, the evaluators should use the data and information presented in the evaluation matrix to build their analysis (or findings) for each evaluation question. The fully completed matrix is an indispensable annex to the report and the evaluation manager will verify that sufficient evidence has been collected to answer all evaluation questions in a credible manner.

As the evaluation matrix plays a crucial role at all stages of the evaluation process, it will require particular attention from both the evaluation team and the evaluation manager. The evaluation matrix will be drafted in the design phase and must be included in the design report. The evaluation matrix will also be included in the annexes of the final evaluation report, to enable the evaluation report's users to access the supporting evidence for the answers to the evaluation questions.

Finalization of the evaluation questions and related assumptions
Based on the preliminary questions presented in the terms of reference (section 5.2) and the theory of change underpinning the CP (see Annex A), the evaluators are required to refine the evaluation questions. In their final form, the questions should reflect the evaluation criteria (section 5.1) and clearly define the key areas of inquiry of the CPE. The final evaluation questions will structure the evaluation matrix (see Annex C) and shall be presented in the design report.

The evaluation questions must be complemented by a set of critical assumptions that capture key aspects of how and why change is expected to occur, based on the theory of change of the CP. This will allow the evaluators to assess whether the preconditions for the achievement of outputs and the contribution of UNFPA to higher-level results, in particular at outcome level, are met. The data collection for each of the evaluation questions and related assumptions will be guided by clearly formulated quantitative and qualitative indicators, which need to be specified in the evaluation matrix.

Sampling strategy
The UNFPA Rwanda CO will provide an initial overview of the interventions supported by UNFPA, the locations where these interventions have taken place, and the stakeholders involved in these interventions. As part of this process, the UNFPA Rwanda CO has produced an initial stakeholder map to identify the range of stakeholders that are directly or indirectly involved in the implementation or affected by the implementation of the CP (see Annex B).

Building on the initial stakeholder map and based on information gathered through document review and discussions with CO staff, the evaluators will develop the final stakeholder map. From this final stakeholder map, the evaluation team will select a sample of stakeholders at national and sub-national levels who will be consulted through interviews and/or group discussions during the data collection phase. These stakeholders must be selected through clearly defined criteria and the sampling approach outlined in the design report (for guidance on how to select a sample of stakeholders see Handbook, pp. 62–63). In the design report, the evaluators should also make explicit what groups of stakeholders were not included and why. The evaluators should aim to select a sample of stakeholders that is as representative as possible, recognizing that it will not be possible to obtain a statistically representative sample.
The evaluation team shall also select a sample of sites that will be visited for data collection and provide the rationale for the selection of the sites in the design report. The UNFPA Rwanda CO will provide the evaluators with necessary information to access the selected locations, including logistical requirements and security risks, if applicable. The sample of sites selected for visits should reflect the variety of interventions supported by UNFPA, both in terms of thematic focus, context, and performance.

The final sample of stakeholders and sites will be determined in consultation with the evaluation manager, based on the review of the design report.

Data collection
The evaluation will consider primary and secondary sources of information. For detailed guidance on the different data collection methods typically employed in CPEs.[111]

Primary data will be collected through semi-structured interviews with key informants at national and sub-national levels (government officials, representatives of implementing partners, civil society organizations, other United Nations organizations, donors, and other stakeholders), as well as group discussions with service providers and rights-holders (notably women, adolescents and youth) and direct observation during visits to selected sites.

Secondary data will be collected through document review, primarily focusing on annual work plans, quarterly work plan progress reports, monitoring data and donor reports for projects of the CO, evaluations and research studies (incl. previous CPEs, mid-term reviews of the CP, evaluations by the UNFPA Evaluation Office, research by international NGOs and other United Nations organizations, etc.), housing census and population data, and records and data repositories of the CP and its implementing partners, such as health clinics/centres. Particular attention will be paid to compiling data on key performance indicators of the UNFPA Rwanda CO during the period of the 8th CP (July 2018-June 2024).

The evaluation team will ensure that data collected is disaggregated by sex, age, location and other relevant dimensions, such as disability status, to the extent possible.

The evaluation team is expected to dedicate a total of 3 weeks for data collection in the field. The data collection tools that the evaluation team will develop, which may include protocols for semi-structured interviews and group discussions, checklists for direct observation at sites visited or a protocol for document review, shall be presented in the design report.

Data analysis
The evaluation matrix will be the major framework for analysing data. The evaluators must enter the qualitative and quantitative data in the evaluation matrix for each evaluation question and each assumption. Once the evaluation matrix is completed, the evaluators should identify common themes and patterns that will help to answer the evaluation questions. The evaluators shall also identify

[111] See Handbook, section 3.4.2, pp. 65–73.

aspects that should be further explored and for which complementary data should be collected, to fully answer all the evaluation questions and thus cover the whole scope of the evaluation.[112]

Validation mechanisms
All findings of the evaluation need to be firmly grounded in evidence. The evaluation team will use a variety of mechanisms to ensure the validity of collected data and information.[113] These mechanisms include (but are not limited to):

- Systematic triangulation of data sources and data collection methods (see Handbook, section 4.2, pp. 94–95).
- Regular and day to day exchange with the evaluation manager at the CO.
- Internal evaluation team meetings to corroborate data and information for the analysis of assumptions, the formulation of emerging findings and the definition of preliminary conclusions; and
- The debriefing meeting with the CO and the ERG at the end of the field phase, when the evaluation team presents the emerging findings of the evaluation.

Data validation is a continuous process throughout the different evaluation phases. The evaluators should check the validity of the collected data and information and verify the robustness of findings at each stage of the evaluation, so they can determine whether they should further pursue specific hypotheses (related to the evaluation questions) or disregard them when there are indications that these are weak (contradictory findings or lack of evidence, etc.).

The validation mechanisms will be presented in the design report.

7. Evaluation Process

The CPE process can be broken down into five different phases that include different stages and lead to different deliverables: preparatory phase; design phase; field phase; reporting phase; and phase of dissemination and facilitation of use. The evaluation manager and the evaluation team leader must undertake quality assurance of each deliverable at each phase and step of the process, with a view to ensuring the production of a credible, useful and timely evaluation.

7.1. Preparatory Phase *(Handbook, pp.35–40)*

The evaluation manager at the UNFPA Rwanda CO will lead the preparatory phase of the CPE, which includes:

- Develop the ToR of the Evaluation Reference group and identify the relevant members.
- Development of the theory of change underlying the CP by CO staff under the leadership and guidance of the M&E officer/evaluation manager.
- Compilation of background information and documentation on the country context and CP for desk review by the evaluation team in the design phase.
- Drafting the terms of reference (ToR) for the CPE with support from the regional M&E adviser in UNFPA ESARO and in consultation with the ERG, and submission of the draft ToR (without annexes) to the UNFPA Evaluation Office for review and approval.
- Publication of the call for the evaluation consultancy.
- Completion of the annexes to the ToR with support of the CO staff, and submission of the draft annexes to the UNFPA Evaluation Office for review and approval.
- Pre-selection of consultants by the CO, pre-qualification of the consultants by the UNFPA Evaluation Office, and recruitment of the consultants by the CO to constitute the evaluation team.

[112] See Handbook, sections 5.1 and 5.2, pp. 115–117.
[113] See Handbook, section 3.4.3, pp. 74–77 for more detailed guidance.

7.2. Design Phase *(Handbook, pp. 43–83)*

In the design phase, the evaluation manager will lay the foundation for communications around the CPE. All other activities will be carried out by the evaluation team, in close consultation with the evaluation manager and the ERG. This phase includes:

- Evaluation kick-off meeting between the evaluation manager and the evaluation team, with the participation of the regional M&E adviser.
- Development of an initial costed communication plan (see Template 16 in the Handbook, p. 279) by the evaluation manager, in consultation with the communication officer in the UNFPA Rwanda CO to support the dissemination and facilitation of use of the evaluation results. The initial communication plan will be updated during each phase of the evaluation, as appropriate, and finalized for implementation during the dissemination and facilitation of use phase.
- Desk review of background information and documentation on the country context and CP, as well as other relevant documentation.
- Detailed review of the theory of change underlying the CP (see Annex A). This includes an analysis of assumptions on which the theory of change is based; contextual factors in which the CP is implemented (how it affect activities and result); indicators of progress in achieving results; links where the causal chain seems to break or are not well established; how results are expected to be sustained after the interventions end, etc.
- Formulation of a final set of evaluation questions based on the preliminary evaluation questions provided in the ToR.
- Development of a final stakeholder map and a sampling strategy to select sites to be visited and stakeholders to be consulted in Rwanda through interviews and group discussions.
- Development of a data collection and analysis strategy, as well as a concrete and feasible evaluation work plan and agenda for the field phase (see Handbook, section 3.5.3, p. 80).
- Development of data collection methods and tools, assessment of limitations to data collection and development of mitigation measures.
- Development of the evaluation matrix (evaluation criteria, evaluation questions, related assumptions, indicators, data collection methods and sources of information). The data and information collected through the documentary review must be inserted in the evaluation matrix. The matrix is placed in a Google drive so it is accessible to all evaluation team members and to the evaluation manager for his/her supervision and quality assurance.

At the end of the design phase, the evaluation team will develop a design report that presents a robust, practical and feasible evaluation approach, detailed methodology and work plan. The evaluation team will develop the design report in consultation with the evaluation manager and the ERG and submit it to the regional M&E adviser in UNFPA ESARO for review. The template for the design report is provided in Annex E.

7.3. Field Phase *(Handbook, pp. 87 –111)*

The evaluation team will collect the data and information required to answer the evaluation questions in the field phase. Towards the end of the field phase, the evaluation team will conduct a preliminary analysis of the data to identify emerging findings that will be presented to the CO and the ERG. The field phase should allow the evaluators sufficient time to collect valid and reliable data to cover the thematic scope of the CPE. A period of 3 weeks for data collection is planned for this evaluation. However, the evaluation manager will determine the optimal duration of data collection, in consultation with the evaluation team during the design phase.

The field phase includes:

- Meeting with the UNFPA Rwanda CO staff to launch the data collection.
- Meeting of the evaluation team with relevant programme officers at the UNFPA Rwanda CO.
- Data collection at national and sub-national levels.

At the end of the field phase, the evaluation team will hold a debriefing meeting with the CO and the ERG to present the emerging findings from the data collection. The meeting will serve as a mechanism for the validation of collected data and information and the exchange of views between the evaluators and important stakeholders. It will enable the evaluation team to refine the findings, which is necessary so they can then formulate their conclusions and develop credible and relevant recommendations.

7.4. Reporting Phase *(Handbook, pp.115 –121)*

In the reporting phase, the evaluation team will continue the analytical work (initiated during the field phase) and prepare a draft evaluation report, taking into account the comments and feedback provided by the CO and the ERG at the debriefing meeting at the end of the field phase.

Prior to the submission of the draft report to the evaluation manager, the evaluation team must perform an internal quality control against the criteria outlined in the Evaluation Quality Assessment (EQA) grid (see Annex F). The evaluation manager and the regional M&E adviser in UNFPA ESARO will subsequently review the draft evaluation report, using the same criteria (defined in the EQA grid). If the quality of the report is satisfactory (in form and substance), the draft report will be circulated to the ERG members for review. In the event that the quality of the draft report is unsatisfactory, the evaluation team will be required to revise the report and produce a second draft.

The evaluation manager will perform his/her review of the draft final report against the completed evaluation matrix (to ensure that the analysis - responses to the evaluation questions - rests on credible data and information and is, in fact, evidence based). S/he will also collect and consolidate the written comments and feedback provided by the members of the ERG. On the basis of the comments, the evaluation team should make appropriate amendments, prepare the final evaluation report and submit it to the evaluation manager. The final report should clearly account for the strength of evidence on which findings rest to support the reliability and validity of the evaluation. Conclusions and recommendations need to clearly build on the findings of the evaluation. Each conclusion shall make reference to the evaluation question(s) upon which it is based, while each recommendation shall indicate the conclusion(s) from which it logically stems.

The evaluation report is considered final once it is technically approved by the evaluation manager on behalf of the reference group and formally approved by UNFPA Rwanda Resident Representative.

At the end of the reporting phase, the evaluation manager and the regional M&E adviser will jointly prepare an internal EQA of the final evaluation report. The Evaluation Office will subsequently conduct the final EQA of the report, which will be made publicly available.

7.5. Dissemination and Facilitation of Use Phase *(Handbook, pp.131 –133)*

In the dissemination and facilitation of use phase, the evaluation team will develop a PowerPoint presentation of the evaluation results that summarizes the key findings, conclusions and recommendations of the evaluation in an easily understandable and user-friendly way.

The evaluation manager will finalize the communication plan together with the communication officer in the UNFPA Rwanda CO. Overall, the communication plan should include information on (i) target audiences of the evaluation; (ii) communication products that will be developed to cater to the target audiences' knowledge needs; (iii) dissemination channels and platforms; and (iv) timelines. At a minimum, the final evaluation report will be accompanied by a PowerPoint presentation of the evaluation results (prepared by the evaluation team) and an evaluation brief (prepared by the evaluation manager).

Based on the final communication plan, the evaluation manager will share the evaluation results with the CO staff (incl. senior management), implementing partners, ESARO, the ERG and other target audiences, as identified in the communication plan. While circulating the final evaluation report to

relevant units in the CO, the evaluation manager will also ensure that these units prepare their response to recommendations that concern them directly. The evaluation manager will subsequently consolidate all responses in a final management response document. In a last step, The UNFPA Rwanda CO will submit the management response to the UNFPA Policy and Strategy Division in HQ.

The evaluation manager, in collaboration with the communication officer in the UNFPA Rwanda CO, will also develop an evaluation brief. This concise note will present the key results of the CPE, thereby making them more accessible to a larger audience (see sections 8 and 10 below).

The final evaluation report, along with the management response and the final EQA will be included in the UNFPA evaluation database.[114] The final evaluation report will also be circulated to the UNFPA Executive Board. Finally, the final evaluation report, the evaluation brief and the management response will be published on the UNFPA Rwanda CO website.

8. Expected Deliverables

The evaluation team is expected to produce the following deliverables:

- Design report. The design report should translate the requirements of the ToR into a practical and feasible evaluation approach, methodology and work plan. It should include (at a minimum): (i) the evaluation approach and methodology (incl. the theory of change and sampling strategy); (ii) the final stakeholder map; (iii) the evaluation matrix (incl. the final evaluation questions, indicators, data sources and data collection methods); (iv) data collection tools and techniques (incl. interview and group discussion protocols); and (v) a detailed evaluation work plan and agenda for the field phase. For guidance on the outline of the design report, see Annex E.
- PowerPoint presentation of the design report. The PowerPoint presentation will be delivered at an ERG meeting to present the contents of the design report and the agenda for the field phase. Based on the comments and feedback of the ERG, the evaluation manager and the regional M&E adviser, the evaluation team will develop the final version of the design report.
- PowerPoint presentation for debriefing meeting with the CO and the ERG. The presentation provides an overview of key emerging findings of the evaluation at the end of the field phase. It will serve as the basis for the exchange of views between the evaluation team, UNFPA Rwanda CO staff (incl. senior management) and the members of the ERG who will thus have the opportunity to provide complementary information and/or rectify the inaccurate interpretation of data and information collected.
- Draft evaluation report. The draft evaluation report will present findings, conclusions and recommendations, based on the evidence that data collection yielded. It will undergo review by the evaluation manager, the CO, the ERG and the regional M&E adviser. Based on the comments and feedback provided by these stakeholders, the evaluation team will develop a final evaluation report.
- Final evaluation report. The final evaluation report *(maximum 70 pages, excluding annexes)* will present the findings and conclusions, as well as a set of practical and actionable recommendations to inform the next programme cycle. For guidance on the outline of the final evaluation report, see Annex G. The set of annexes must be complete and must include the evaluation matrix containing all supporting evidence (data and information).
- PowerPoint presentation of the evaluation results. The presentation will provide a clear overview of the key findings, conclusions and recommendations to be used for the dissemination of the final evaluation report.

[114] The UNFPA evaluation database can be accessed at the following link: https://web2.unfpa.org/public/about/oversight/evaluations/documentList.unfpa.

Based on these deliverables, the evaluation manager, in collaboration with the communication officer in the UNFPA Rwanda CO will develop an:

- Evaluation brief. The evaluation brief will consist of a short and concise document that provides an overview of the key evaluation results in an easily understandable and visually appealing manner, to promote their use among decision-makers and other stakeholders. The structure, content and layout of the evaluation brief should be similar to the briefs that the UNFPA Evaluation Office produces for centralized evaluations.

All the deliverables will be developed in the English language.

9. Quality Assurance and Assessment

The UNFPA Evaluation Quality Assurance and Assessment (EQAA) system aims to ensure the production of good quality evaluations at central and decentralized levels through two processes: quality assurance and quality assessment. Quality assurance occurs throughout the evaluation process, starting with the ToR of the evaluation and ending with the final evaluation report. Quality assessment takes place following the completion of the evaluation process and is limited to the final evaluation report to assess compliance with a certain number of criteria. The quality assessment will be conducted by the independent UNFPA Evaluation Office.

The EQAA of this CPE will be undertaken in accordance with the guidance and tools that the independent UNFPA Evaluation Office developed (see https://www.unfpa.org/admin-resource/evaluation-quality-assurance-and-assessment-tools-and-guidance). An essential component of the EQAA system is the EQA grid (see Handbook, pp. 268–276 and Annex F), which defines a set of criteria against which the draft and final evaluation reports are assessed to ensure clarity of reporting, methodological robustness, rigor of the analysis, credibility of findings, impartiality of conclusions and usefulness of recommendations.

The evaluation manager is primarily responsible for quality assurance of the deliverables of the evaluation in each phase of the evaluation process. However, the evaluation team leader also plays an important role in undertaking quality assurance. The evaluation team leader must ensure that all members of the evaluation team provide high-quality contributions (both form and substance) and, in particular, that the draft and final evaluation reports comply with the quality assessment criteria outlined in the EQA grid (Annex F)[115] before submission to the evaluation manager for review. The evaluation quality assessment checklist below outlines the main quality criteria that the draft and final version of the evaluation report must meet.

1. Structure and Clarity of the Report Ensure the report is clear, user-friendly, comprehensive, logically structured and drafted in accordance with standards and practices of international organizations, including the editorial guidelines of the UNFPA Evaluation Office (see Annex I).
2. Executive Summary Provide an overview of the evaluation, written as a stand-alone section, including the following key elements of the evaluation: Purpose of the evaluation and target audiences; objectives of the evaluation and brief description of the country programme; methodology; main conclusions; and recommendations.
3. Design and Methodology

[115] The evaluators are invited to look at good quality CPE reports that can be found in the UNFPA evaluation database, which is available at: https://web2.unfpa.org/public/about/oversight/evaluations/. These reports must be read in conjunction with their EQAs (also available in the database) in order to gain a clear idea of the quality standards that UNFPA expects the evaluation team to meet.

Provide a clear explanation of the methods and tools used, including the rationale for the methodological approach and the appropriateness of the methods selected to capture the voices/perspectives of a range of stakeholders, including vulnerable and marginalized groups. Ensure constraints and limitations are made explicit (incl. limitations applying to interpretations and extrapolations in the analysis; robustness of data sources, etc.)
4. Reliability of Data Ensure sources of data are clearly stated for both primary and secondary data. Provide explanation on the credibility of primary (e.g. interviews and group discussions) and secondary (e.g. documents) data collected and make limitations explicit.
5. Analysis and Findings Ensure sound analysis and credible, evidence-based findings. Ensure interpretations are based on carefully described assumptions; contextual factors are identified; cause-and-effect links between an intervention and its end results (incl. unintended results) are explained.
6. Validity of Conclusions Ensure conclusions are based on credible findings and convey the evaluators' unbiased judgment of the intervention. Ensure conclusions are presented in order of priority; divided into strategic and programmatic conclusions (for guidance, see Handbook, p. 238); briefly summarized in a box that precedes a more detailed explanation; and for each conclusion its origin (on which evaluation question(s) the conclusion is based) is indicated.
7. Usefulness and Clarity of Recommendations Ensure recommendations flow logically from conclusions, are realistic and operationally feasible. Ensure recommendations are presented in order of priority; divided into strategic and programmatic recommendations (as done for conclusions); briefly summarized in a box that precedes a more detailed explanation of the main elements of the recommendation and how it could be implemented effectively. For each recommendation, indicate a priority level (high/moderate/low), a target (administrative unit(s) to which the recommendation is addressed), and its origin (which conclusion(s) the recommendation is based on).
8. United Nations System-wide Action Plan (SWAP) Evaluation Performance Indicator – Gender Equality Ensure the evaluation approach is aligned with the United Nations SWAP on Gender Equality and the Empowerment of Women[116] and UNEG guidance on integrating human rights and gender perspectives in evaluation.[117]

Using the grid in Annex F, the EQAA process for this CPE will be multi-layered and will involve: (i) the evaluation team leader (and each evaluation team member); (ii) the evaluation manager in the UNFPA Rwanda CO, (iii) the regional M&E adviser in UNFPA ESARO, and (iv) the UNFPA Evaluation Office, whose roles and responsibilities are described in section 11.

10. Indicative Timeframe and Work Plan

The table below indicates all the activities that will be undertaken throughout the evaluation process, as well as their duration or specific dates for the submission of corresponding deliverables. It also indicates all relevant guidance (tools and templates) that can be found in the UNFPA Evaluation Handbook.

[116] Guidance on the SWAP Evaluation Performance Indicator and its application to evaluation is available at: http://www.unevaluation.org/document/detail/1452.

[117] The UNEG Guidance on Integrating Human Rights and Gender Equality in Evaluations is available at http://www.uneval.org/document/detail/980.

Nota Bene: Column "Deliverables": In italics: The deliverables are the responsibility of the CO/evaluation manager; in bold: The deliverables are the responsibility of the evaluation team.

Evaluation Phases and Activities[118]	Deliverables	Dates/Duration	Handbook/CPE Management Kit
Preparatory Phase			
Preparation of letter for Government and other key stakeholders to inform them about the upcoming CPE	*Letter from the UNFPA Country Representative*	*Week 2, March*	
Establishment of the evaluation reference group (ERG)		*Week 3, March*	Template 14: Letter of Invitation to Participate in a Reference Group, p. 277
Development of the ToC underpinning the CP by CO staff (at the request of CO senior management and with support of the M&E officer/evaluation manager)	*ToC (include in Annex A of the ToR)*	*Week 3, February*	Tool 2: The Effects Diagram, pp. 161–163[119]
Compilation of background information and documentation on the country context and the CP for desk review by the evaluation team	*Creation of a Google Drive folder containing all relevant documents on country context and CP*	*Week 3, March*	Tool 8: Checklist for the Documents to be Provided by the Evaluation Manager to the Evaluation Team, pp. 179–183 CPE Management Kit: Document Repository Checklist
Drafting the terms of reference (ToR) based on the ready-to-use ToR (R2U ToR) template	*Draft ToR*	*Week 2, March*	CPE Management Kit: Evaluation Office Ready-to-Use ToR (R2U ToR) Template
Quality Assurance of the draft ToR by ESARO M&E Advisor	*ToR with feedback*	*Week 2–3, March*	
Review and approval of the ToR by the UNFPA Evaluation Office	*ToR with feedback*	*Week 1–2, April*	
Finalize the ToR based on the RO/EO feedback	*Final ToR with comments all addressed*	*Week 2, April*	
Publication of the call for the evaluation consultancy		*Week 3–4, April*	CPE Management Kit: Call for Evaluation Consultancy Template
Completion of the annexes to the ToR (in consultation with the regional M&E adviser and with input from CO staff)	*Draft ToR annexes*	*Week 2 March – Week 3 April*	Template 4: The Stakeholders Map, p. 255 Tool 4: The Stakeholders Mapping Table, p. 166–167 Template 3: List of Atlas Projects by Country Programme Output and

[118] The activities of the different evaluation phases noted in this table do not necessarily follow the presentation of activities in the UNFPA Evaluation Handbook because they are ordered chronologically and include some additional activities, based on best practices within UNFPA.

[119] The Effects Diagram depicts the results chain (intervention logic) underlying the CP and, as such, is similar to a ToC. However, a ToC goes beyond the results chain and also describes the critical assumptions and contextual factors that affect the achievement of intended results.

			Strategic Plan Outcome, pp. 253–254 Tool 3: List of UNFPA Interventions by Country Programme Output and Strategic Plan Outcome, pp. 164–165 Template 15: Work Plan, p. 278 CPE Management Kit: Establishing the list of UNFPA interventions (Atlas projects)
Pre-selection of consultants by the CO	*Consultant pre-selections scorecard*	*Week 4, April*	CPE Management Kit: Consultant Pre-selection Scorecard
Review and approval of the annexes to the ToR by the UNFPA Evaluation Office	*ToR annexes with feedback*	*Week 4, April*	
Finalize the annexes based on the RO/EO feedback	*Final ToR annexes*	*Week 3, April*	
Pre-qualification of consultants by the UNFPA Evaluation Office		*Week 4, April*	
Recruitment of the evaluation team by the CO		*Week 1–3, May*	
Design Phase			
Evaluation kick-off meeting between the evaluation manager, the evaluation team and the regional M&E adviser		*Week 4, May*	
Development of an initial communication plan by the evaluation manager (in consultation with the communication officer in the CO)	*Initial communication plan*	*Week 4, May*	Template 16: Communication Plan for Sharing Evaluation Results, p. 279 CPE Management Kit: Guidance on Strategic Communication for a CPE
Desk review of background information and documentation on the country context and the CP (incl. bibliography and resources in the ToR)		*Week 4, May*	
Drafting of the design report (incl. approach and methodology, ToC, evaluation questions, duly completed evaluation matrix, final stakeholder map and sampling strategy, evaluation work plan and agenda for the field phase)	Draft design report	*Week 1, June*	Template 8: The Design Report for CPE, pp. 259–261 Tool 5: The Evaluation Questions Selection Matrix, pp. 168–169 Tool 1: The Evaluation Matrix, pp. 138–160 Template 5: The Evaluation Matrix, pp. 256 Template 15: Work Plan, p. 278

			Tool 10: Guiding Principles to Develop Interview Guides, pp. 185–187 Tool 11: Checklist for Sequencing Interviews, p. 188 Template 7: Interview Logbook, p. 258 Tool 9: Checklist of Issues to be Considered When Drafting the Agenda for Interviews, pp. 183–187 Template 6: The CPE Agenda, p. 257 Tool 6: The CPE Agenda, pp. 170–176 CPE Management Kit: Compilation of Resources for Remote Data Collection (if applicable)
Review of the draft design report by the evaluation manager and the regional M&E adviser	*Consolidated feedback provided by evaluation manager to evaluation team leader*	*Week 2–3 June*	
Presentation of the draft design report to the ERG for comments and feedback	PowerPoint presentation of the draft design report	*Week 4 June*	
Revision of the draft design report and circulation of the final version to the evaluation manager for approval	Final design report	*Week 4 June*	
Update of the communication plan by the evaluation manager, in particular target audiences and timelines (based on the final stakeholder map and the evaluation work plan presented in the approved design report)	*Updated communication plan*	*Week 4 June*	Template 16: Communication Plan for Sharing Evaluation Results, p. 279 CPE Management Kit: Guidance on Strategic Communication for a CPE
Field Phase			
Inception meeting for data collection with CO staff	*Meeting between evaluation team/CO staff*	*Week 1 July*	Tool 7: Field Phase Preparatory Tasks Checklist, pp. 177–183
Individual meetings with relevant CO programme officers	*Meeting of evaluators/CO programme officers*	*Week 1 July*	
Data collection (incl. interviews with key informants, site visits for direct observation, group discussions, document review, etc.)	Entering data/information into the evaluation matrix	*Week 2–3 July*	Tool 12: How to Conduct Interviews: Interview Logbook and Practical Tips, pp. 189–202 Tool 13: How to Conduct a Focus Group: Practical Tips, pp. 203–205

			Template 9: Note of the Results of the Focus Group, p. 262 CPE Management Kit: Compilation of Resources for Remote Data Collection (if applicable)
Debriefing meeting with CO staff and the ERG to present emerging findings and preliminary conclusions after data collection	PowerPoint presentation for debriefing with the CO and the ERG	*Week 4 July*	
Update of the communication plan by the evaluation manager (as required)	*Updated communication plan*	*Week 4 July*	Template 16: Communication Plan for Sharing Evaluation Results, p. 279 CPE Management Kit: Guidance on Strategic Communication for a CPE
Reporting Phase			
Drafting of the evaluation report and circulation to the evaluation manager	Draft evaluation report	*Week 1–2 August*	Template 10: The Structure of the Final Report, pp. 253–264 Template 11: Abstract of the Evaluation Report, p. 265 Template 18: Basic Graphs and Tables in Excel, p. 288
Review of the draft evaluation report by the evaluation manager, the ERG and the regional M&E adviser	*Consolidated feedback provided by evaluation manager to evaluation team leader*	*Week 3–4 August*	
Drafting of the final evaluation report (incl. annexes) and circulation to the evaluation manager	Final evaluation report (incl. annexes)	*Week 1–2 September*	
Joint development of the EQA of the final evaluation report by the evaluation manager and the regional M&E adviser	*EQA of the draft evaluation report (by the evaluation manager and the regional M&E adviser)*	*Week 3–4 September*	Template 13: Evaluation Quality Assessment Grid and Explanatory Note, pp. 269–276 Tool 14: Summary Checklist for Human Rights and Gender Equality in the Evaluation Process, pp. 206–207 Tool 15: United Nations SWAP Individual Evaluation Performance Indicator Scorecard, pp. 208–209
Circulation of the final evaluation report to the UNFPA Evaluation Office		*Week 1 October*	
Preparation of the independent EQA of the final evaluation report by the UNFPA Evaluation Office	*Independent EQA of the final evaluation report (by the UNFPA Evaluation Office)*	*Week 1–2 October*	

Update of the communication plan by the evaluation manager (as required)	*Updated communication plan*	*Week 1–2 October*	Template 16: Communication Plan for Sharing Evaluation Results, p. 279 CPE Management Kit: Guidance on Strategic Communication for a CPE
Dissemination and Facilitation of Use Phase			
Preparation of the management response by the CO and submission to the Policy and Strategy Division	*Management response*	*Week 2–3 October*	Template 12: Management Response, pp. 266–267
Finalization of the communication plan and preparation for its implementation by the evaluation manager, with support from the communication officer in the CO	*Final communication plan*	*Week 3 October*	Template 16: Communication Plan for Sharing Evaluation Results, p. 279 CPE Management Kit: Guidance on Strategic Communication for a CPE
Development of the presentation on the evaluation results	PowerPoint presentation of the evaluation results	*Week 3 October*	Example of PowerPoint presentation (for a centralized evaluation undertaken by the UNFPA Evaluation Office): https://www.unfpa.org/sites/default/files/admin-resource/FINAL_MTE_Supplies_PPT_Long_version.pdf
Development of the evaluation brief by the evaluation manager, with support from the communication officer in the CO	*Evaluation brief*	*Week 4 October – Week 2 November*	Example of evaluation brief (for a centralized evaluation undertaken by the UNFPA Evaluation Office): https://www.unfpa.org/sites/default/files/admin-resource/UNFPA_MTE_Supplies_Brief_FINAL.pdf
Announcement of CPE completion in M&E Net Community	*Blog post on the M&E Net Community*	*Week 2 November*	CPE Management Kit: Guidance on How to Blog on The CPE Process
Publication of the final evaluation report, the independent EQA and the management response in the UNFPA evaluation database by the Evaluation Office		*Week 3 November*	
Publication of the final evaluation report, the evaluation brief and the management response on the CO website		*Week 3 November*	
Dissemination of the evaluation report and the evaluation brief to stakeholders by the evaluation manager	*Including: Communication via email; stakeholders meeting; workshops with implementing partners, etc.*	*Week 4 November-Week 1December*	CPE Management Kit: Guidance on Strategic Communication for a CPE

Once the evaluation team leader has been recruited, s/he will develop a detailed evaluation work plan (see Annex I) in close consultation with the evaluation manager.

11. Management of the Evaluation

The evaluation manager in the UNFPA Rwanda CO will be responsible for the management of the evaluation and supervision of the evaluation team in line with the UNFPA Evaluation Handbook. The evaluation manager will oversee the entire process of the evaluation, from the preparation to the facilitation of the use and the dissemination of the evaluation results. S/he will also coordinate the exchanges between the evaluation team and the ERG. It is the responsibility of the evaluation manager to ensure the quality, independence and impartiality of the evaluation in line with the UNEG norms and standards and ethical guidelines for evaluation. The evaluation manager has the following key responsibilities:

12. Composition of the Evaluation Team

The evaluation will be conducted by a team of independent, external evaluators, consisting of: (i) an evaluation team leader with overall responsibility for carrying out the evaluation exercise, and (ii) team members who will provide technical expertise in thematic areas relevant to the UNFPA mandate (SRHR; adolescents and youth; gender equality and women's empowerment; and population dynamics). In addition to his primary responsibility for the design of the evaluation methodology and the coordination of the evaluation team throughout the CPE process, the team leader will perform the role of technical expert for one of the thematic areas of the 8th UNFPA CP in Rwanda.

The evaluation team leader will be recruited internationally (incl. in the region or sub-region), while the evaluation team members will be recruited locally to ensure adequate knowledge of the country context. Finally, the evaluation team should have the requisite level of knowledge to conduct human rights- and gender-responsive evaluations and all evaluators should be able to work in a multidisciplinary team and in a multicultural environment.

12.1. Roles and Responsibilities of the Evaluation Team

Evaluation team leader

The evaluation team leader will hold the overall responsibility for the design and implementation of the evaluation. S/he will be responsible for the production and timely submission of all expected deliverables in line with the ToR. S/he will lead and coordinate the work of the evaluation team and ensure the quality of all evaluation deliverables at all stages of the process. The evaluation manager will provide methodological guidance to the evaluation team in developing the design report, in particular, but not limited to, defining the evaluation approach, methodology and work plan, as well as the agenda for the field phase. S/he will lead the drafting and presentation of the design report and the draft and final evaluation report, and play a leading role in meetings with the ERG and the CO. The team leader will also be responsible for communication with the evaluation manager. Beyond her/his responsibilities as team leader, the evaluation team leader will serve as technical expert for one of the thematic areas of the CP described below.

Evaluation team member: SRHR expert

The SRHR expert will provide expertise on integrated SRH services, HIV and other sexually transmitted infections, maternal health, and family planning. S/he will contribute to the methodological design of the evaluation and take part in the data collection and analysis work, with overall responsibility of contributions to the evaluation deliverables in her/his thematic area of expertise. S/he will provide substantive inputs throughout the evaluation process by contributing to the development of the evaluation methodology, evaluation work plan and agenda for the field phase, participating in meetings with the evaluation manager, UNFPA Rwanda CO staff and the ERG. S/he will undertake a document review and conduct interviews and group discussions with stakeholders, as agreed with the evaluation team leader.

Evaluation team member: Adolescents and youth expert

The adolescents and youth expert will provide expertise on youth-friendly SRHR services, comprehensive sexuality education, adolescent pregnancy, SRHR of young women and adolescent

girls, access to contraceptives for young women and adolescent girls and youth leadership and participation. S/he will contribute to the methodological design of the evaluation and take part in the data collection and analysis work, with overall responsibility of contributions to the evaluation deliverables in her/his thematic area of expertise. S/he will provide substantive inputs throughout the evaluation process by contributing to the development of the evaluation methodology, evaluation work plan and agenda for the field phase, participating in meetings with the evaluation manager, UNFPA Rwanda CO staff and the ERG. S/he will undertake a document review and conduct interviews and group discussions with stakeholders, as agreed with the evaluation team leader.

Evaluation team member: Population dynamics expert
The population dynamics expert will provide expertise on population and development issues, such as census, aging, migration, the demographic dividend, and national statistical systems. S/he will contribute to the methodological design of the evaluation and take part in the data collection and analysis work, with overall responsibility of contributions to the evaluation deliverables in her/his thematic area of expertise. S/he will provide substantive inputs throughout the evaluation process by contributing to the development of the evaluation methodology, evaluation work plan and agenda for the field phase, participating in meetings with the evaluation manager, UNFPA Rwanda CO staff and the ERG. S/he will undertake a document review and conduct interviews and group discussions with stakeholders, as agreed with the evaluation team leader.

The modalities for the participation of the evaluation team members in the evaluation process, their responsibilities during data collection and analysis, as well as the nature of their respective contributions to the drafting of the design report and the draft and final evaluation report will be agreed with the evaluation team leader. These tasks will be performed under her/his supervision.