End Line Evaluation

UNFPA Rwanda 6th Country Programme

Centre for Sustainable International Development, University of Aberdeen, UK and
Institute of Policy Analysis and Research, Rwanda

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Local consultants: Institute for Policy and Research, Rwanda: Dixon Malunda, Liliane Mutesi, Godfrey Ngoboka, Lonzen Rugira and John Rwirahira
Source: NISR¹

### Key Facts: Rwanda

#### Land

<table>
<thead>
<tr>
<th>Geographical location</th>
<th>Great Lakes Region of Central Africa.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land area</td>
<td>26,383 sq km</td>
</tr>
<tr>
<td>Terrain</td>
<td>Mostly grassy uplands and hills.</td>
</tr>
<tr>
<td>Population density</td>
<td>407 per kilometre</td>
</tr>
</tbody>
</table>

#### People

<table>
<thead>
<tr>
<th>Population</th>
<th>10,718,379</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban/Rural</td>
<td>19% urban/81% rural</td>
</tr>
<tr>
<td>Population Growth Rate</td>
<td>2.9% p.a.</td>
</tr>
</tbody>
</table>

#### Government

<table>
<thead>
<tr>
<th>Government</th>
<th>Republic; Constitution adopted 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key political events</td>
<td>1994 Genocide against the Tutsi</td>
</tr>
<tr>
<td></td>
<td>2003 Adoption of Constitution</td>
</tr>
<tr>
<td></td>
<td>2008 Membership of East African Community</td>
</tr>
<tr>
<td></td>
<td>2009 Membership British Commonwealth</td>
</tr>
<tr>
<td></td>
<td>2010 Paul Kagame elected as President for 2nd term</td>
</tr>
</tbody>
</table>

| % Seats held by Women in National Parliament | 56% in House of Representatives |

#### Economy

<table>
<thead>
<tr>
<th>GDP per capita</th>
<th>US$540 in 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP Growth Rate</td>
<td>7.1% fiscal year 2010/22</td>
</tr>
<tr>
<td>Main industries</td>
<td>Coffee, tea, mining, tourism</td>
</tr>
</tbody>
</table>

#### Social indicators

<table>
<thead>
<tr>
<th>Human Development Index Rank</th>
<th>152</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Population below National Poverty Line</td>
<td>57% 2005/6</td>
</tr>
<tr>
<td>Life expectancy at birth</td>
<td>55 years</td>
</tr>
<tr>
<td>Infant Mortality Rate (per 1000 live births)</td>
<td>50 per 1000 live births 2010 DHS</td>
</tr>
<tr>
<td>Under 5Mortality Rate (per 1000 live births)</td>
<td>76 per 1000 live births 2010 DHS</td>
</tr>
<tr>
<td>Maternal Mortality Rate (per 100,000 live births)</td>
<td>750 DHS 2005 (estimated 383 in 2008)</td>
</tr>
<tr>
<td>Health Expenditure (% Government Budget)</td>
<td>9.2%</td>
</tr>
<tr>
<td>Births Attended by Skilled Health Personnel</td>
<td>69% 2010 DHS</td>
</tr>
<tr>
<td>Adolescent Fertility Rate (births per 1000 women aged 15-19)</td>
<td>41 2010 DHS</td>
</tr>
<tr>
<td>People Living With HIV/AIDS</td>
<td>3% 2005 DHS</td>
</tr>
<tr>
<td>Adult Literacy Rate – Male/Female/Total</td>
<td>M 75% F 67% T 71%</td>
</tr>
<tr>
<td>Net Primary School Enrolment- Boys/Girls/Total</td>
<td>B 91.6% G 94.1% T 92.9%</td>
</tr>
<tr>
<td>Gross Primary School Completion Rates</td>
<td>74.5%</td>
</tr>
<tr>
<td>% Employed in Non-farm work</td>
<td>M 28% / W 12% (2006)</td>
</tr>
</tbody>
</table>

#### MDGs

| Goal 1: Eradicate Extreme Poverty and Hunger | Off track* |
| Goal 2: Achieve Universal Primary Education | Very likely to be achieved |
| Goal 3: Promote Gender Equality and Empower Women | Very likely to be achieved |
| Goal 4: Reduce Child Mortality | Potential to achieve |
| Goal 5: Improve Maternal Health | Potential to achieve |
| Goal 6: Combat HIV/AIDS, Malaria and Other Diseases | Very likely to be achieved |
| Goal 7: Ensure Environmental Sustainability | Potential to achieve Water and Sanitation |
| Goal 8 Develop a Global Partnership for Development | Potential to be achieved in part |

---

*Green = On Track, Amber = Potential to Achieve with Accelerated Progress, Red = Off Track
#### UNFPA Alignment to National Priorities at a Glance

<table>
<thead>
<tr>
<th>EDPRS</th>
<th>UNAF</th>
<th>UNAF Results Area</th>
<th>UNFPA Contribution</th>
<th>UNFPA Operational Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decentralisation, Citizen Participation and Accountability</td>
<td>Governance</td>
<td>Governance</td>
<td>Evidenced Based Policy Making</td>
<td>Population and Development</td>
</tr>
<tr>
<td>Justice, Reconciliation, Law and Order</td>
<td></td>
<td></td>
<td>Gender Equality</td>
<td>Gender</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>Effective Health System</td>
<td></td>
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<td></td>
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<td></td>
<td>Health Practices</td>
<td></td>
</tr>
<tr>
<td>Health Population</td>
<td>Education</td>
<td>Education</td>
<td>Education Achievement</td>
<td>Population and Development</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Gender</td>
<td>Gender</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Sexual and Reproductive Health</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Social Protection</td>
<td>Sustainable Growth and Social Protection</td>
<td>Social Protection and Sustainable Development</td>
<td>Production and Income</td>
<td>Sexual and Reproductive Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Effective National Disaster Management</td>
<td>Gender</td>
</tr>
<tr>
<td>Agriculture, Animal Resources and Employment Promotion</td>
<td></td>
<td></td>
<td>Social Protection</td>
<td>Population and Development (Data in Emergency Situations)</td>
</tr>
</tbody>
</table>
Acknowledgements

First and foremost we would like to thank all the people who provided us with information and answered our questions. Without their cooperation it would not have been possible to carry out this evaluation. We cannot thank them enough for the time they have given to help us.

We would like to acknowledge the support and help we have received from staff of the UNFPA Rwanda Country Office throughout the evaluation. We would especially like to thank Robert Banamwana who provided us with documentation and facilitated our access to key informants and beneficiaries. We are very grateful to the staff at the University of Aberdeen who provided logistical support, especially Shelagh Barr of Ipact.

Finally, we are grateful to the research assistants on the project: Emmanuel Munyemana, Marklin Rucogoza, Anne Marie Uwimana and Lisa Pacific Vuningoma.

Disclaimer
This work was coordination by Ipact, see: http://www.Ipact-int.com and undertaken by the Centre for Sustainable International Development at the University of Aberdeen, UK and the Institute of Policy and Analysis and Research, Rwanda. The views expressed in this paper are solely those of the authors.

About Ipact
Ipact specializes in providing technical assistance in the monitoring and evaluation of maternal and neonatal health programmes in developing countries. We prioritize consultative and participatory approaches and endeavour to work alongside locally-based institutes, enabling sharing of experiences and skills, and building capacity for measurement. Ipact operates within a strong research environment at the University of Aberdeen in Scotland and is closely linked to the work of Immpact, an international research initiative for maternal mortality reduction.

Centre for Sustainable International Development
The Centre for Sustainable International Development was established at the University of Aberdeen in September 2010 to facilitate and generate work on sustainable international development across the University. It espouses an inter-disciplinary, multi-sectoral approach and aims to make a significant contribution to the achievement of the Millennium Development Goals and other international development targets.

Institute of Policy Analysis and Research
The Institute of Policy Analysis and Research (IPAR) is the only independent local think tank in Rwanda. It undertakes public policy evaluation and research in Rwanda and the East African Region. IPAR aims to provide evidence informed policy recommendations to the government, development partners and other stakeholders. It has a strong commitment to improving the lives of ordinary Rwandans.
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<th>Full Form</th>
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<tr>
<td>ARBEF</td>
<td>Association Rwandaise pour la Bien-être de la Famille (Rwanda Association for Family Welfare)</td>
</tr>
<tr>
<td>AWP</td>
<td>Annual Work Plan</td>
</tr>
<tr>
<td>BBS</td>
<td>Behavioural Biological Survey</td>
</tr>
<tr>
<td>CAP</td>
<td>Consolidated Annual Plan</td>
</tr>
<tr>
<td>CBD</td>
<td>Community-based development</td>
</tr>
<tr>
<td>CHW</td>
<td>Community Health Worker</td>
</tr>
<tr>
<td>CNLS</td>
<td>Commission Nationale de Lutte contre le SIDA (National AIDS Council)</td>
</tr>
<tr>
<td>CO</td>
<td>Country Office</td>
</tr>
<tr>
<td>COD</td>
<td>Common Operational Document</td>
</tr>
<tr>
<td>CP</td>
<td>Country Programme</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil society organization</td>
</tr>
<tr>
<td>DAD</td>
<td>Development Assistance Database</td>
</tr>
<tr>
<td>DaO</td>
<td>Delivering as One</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic Health Survey</td>
</tr>
<tr>
<td>EDPRS</td>
<td>Economic Development and Poverty Reduction Strategy</td>
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<tr>
<td>EMIS</td>
<td>Education Management Information System</td>
</tr>
<tr>
<td>EMONC</td>
<td>Emergency Obstetric and Neo-natal Care</td>
</tr>
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<td>EU</td>
<td>European Union</td>
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<td>FBO</td>
<td>Faith-based Organization</td>
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<td>FP</td>
<td>Family Planning</td>
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<td>FY</td>
<td>Financial Year</td>
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<td>GBV</td>
<td>Gender-based Violence</td>
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<td>GRB</td>
<td>Gender Responsive Budgeting</td>
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<td>GFATM</td>
<td>Global Fund for AIDS, Tuberculosis and Malaria</td>
</tr>
<tr>
<td>GMO</td>
<td>Gender Monitoring Office</td>
</tr>
<tr>
<td>GNI</td>
<td>Gross National Income</td>
</tr>
<tr>
<td>GPHC</td>
<td>General Population and Housing Census</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immune-deficiency Virus</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
</tr>
<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
</tr>
<tr>
<td>ICT</td>
<td>Information and communication technology</td>
</tr>
<tr>
<td>IMIS</td>
<td>Integrated Management Information System</td>
</tr>
<tr>
<td>IMR</td>
<td>Infant Mortality Ratio</td>
</tr>
<tr>
<td>IP</td>
<td>Implementing Partner</td>
</tr>
<tr>
<td>IPAR</td>
<td>Institute for Policy and Research, Rwanda</td>
</tr>
<tr>
<td>KCC</td>
<td>Kigali City Council</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
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<tr>
<td>MIFORA</td>
<td>Ministry of Public Service, Skills development and Labour</td>
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<tr>
<td>MIGEPROF</td>
<td>Ministry of Gender and Family Promotion</td>
</tr>
<tr>
<td>MIZESPOC</td>
<td>Ministry of Youth, Sport and Culture</td>
</tr>
<tr>
<td>MINALOC</td>
<td>Ministry of Local Government, Good Governance, Community Development &amp; Social Affairs</td>
</tr>
</tbody>
</table>
MINECOFIN  Ministry of Finance and Economic Planning
MINEDUC  Ministry of Education
MINISANTE  Ministry of Health
MMR  Maternal Mortality Ratio
MTR  Mid-Term Review
NEPAD  New Partnership for Africa’s Development
NGO  Non-governmental organization
NISR  National Institute of Statistics, Rwanda
NWC  National Women’s Council
ODA  Official Development Assistance
ODP  Official Development Partners
OECD  Office of European Development Cooperation
PEPFAR  The United States President’s Emergency Plan for AIDS Relief
PIU  Project Implementation Unit
PMF  Performance Management Framework
PMTCT  Prevention of mother to child transmission of HIV
PPP  Public private partnerships
RALGA  Rwanda Association of Local Government Authorities
RBP&  Results-based Monitoring and Evaluation
RNP  Rwandan National Police
RPRPD  Network of Rwandan Parliamentarians on Population and Development
SMART  Specific, Measurable, Achievable, Realistic, Time bound
SMS  Short message service
SP  Strategic Plan
SPAS  Service Provision Assessment
SRH  Sexual and Reproductive Health
STI  Sexually Transmitted Infection
SWAp  Sector wide Approach
TFR  Total Fertility Rate
TRAC  Treatment and Research AIDS Centre
UN  United Nations
UNAIDS  United Nations Joint Programme on AIDS
UNCT  United Nations County Team
UNDAF  United Nations Development Assessment Framework
UNDP  United Nations Development Programme
UNICEF  United Nations Children’s Fund
UNWomen  United Nations entity for Gender Equality and the Empowerment of Women
UPS  Uninterruptible Power Supply
US  United States (of America)
USAID  United States Agency for International Development
VCT  Voluntary Counselling and Testing for HIV
WFP  World Food Programme
WHO  World Health Organization
YFC  Youth Friendly Centre
YFHS  Youth Friendly Health Service
Executive Summary

A team of international and local experts conducted an independent End Line Evaluation of the UNFPA 6th Rwanda Country Programme (CP) during September and October 2011 so that key findings and recommendations could feed into the development of the UNFPA 7th Country Programme due to start in July 2013.

Evaluation objectives
The main objectives of the evaluation were to assess the overall UNFPA performance and contribution, to draw lessons and make recommendations for the next programme cycle. There were two main components to the evaluation: how UNFPA programme outcomes have contributed to development results, and an assessment of UNFPA-adopted strategies.

Evaluation methodology
The evaluation followed a standard evaluation methodology examining all programme components against criteria such as effectiveness, efficiency, responsiveness, strategic relevance and sustainability, as well as the added value of the United Nations working as one. A contribution analysis and a cost analysis were also carried out. There were four stages to the evaluation: desk research and review of relevant documentation; data collection involving interviewing UNFPA staff, implementation partners, key government officials and beneficiaries; report writing; and quality assurance.

UNFPA 6th Country Programme
The UNFPA 6th CP covers the period January 2008 to June 2013. The programme budget is US$ 30 million of which US$ 10 million is from regular resources and US$ 20 million is through co-financing modalities. The Paris Declaration on Aid Effectiveness provides the methodological approach adopted, with the Government of Rwanda managing the assistance.

The 6th CP is derived from the United Nations Development Assistance Framework (UNDAF) developed by the UN agencies in Rwanda, operating within the One UN Framework to respond to the national priorities as laid out in Vision 2020 and the Economic Development and Poverty Reduction Strategy (EDPRS). The thematic priorities and indicators included in both Vision 2020 and EDPRS are consistent with the Millennium Development Goals (MDGs).

The overall aim of the UNFPA 6th CP is to contribute to the improvement of the socio-economic situation of people in Rwanda and to reduce their vulnerability through contributing to four of the five UNDAF results, namely:
1. good governance is enhanced and sustained
2. the growth of the population is reduced, with marked improvement in maternal and child health, and the impact of HIV and other major epidemics is reduced
3. all children in Rwanda acquire a quality basic education and skills for a knowledge-based economy
4. all people in Rwanda benefit from economic growth, including productive employment, and are less vulnerable to social and economic shocks (sustainable growth and social protection).

The UNFPA 6th CP programme is delivered through three components at national and local levels: Reproductive health (RH); Population and development (PD); and Gender.

The main focus is on UNFPA technical and financial support nationally to four ministries (Ministry of Finance and Economic Planning - MINECOFIN, Ministry of Gender and Family Promotion - MIGEPROF, Ministry of Health - MINISANTE, and Ministry of Youth, Sport and Culture - MIJESPOC), the Forum of
Women Members of Parliament, the Gender Monitoring Office, the Network of Parliamentarians on Population and Development and the National Institute of Statistics, Rwanda (NISR).

At a decentralised level UNFPA support was initially for 14 district authorities and hospitals, but this was reduced to five following the Mid-term Review of the 6th CP conducted in 2010. The five districts UNFPA supports were selected because of their relatively poor RH performance and higher rates of HIV infection.

**Key findings**

UNFPA support to Rwanda is well aligned with the Fund’s strategic plan, including support for disadvantaged and vulnerable groups. Capacity development is also well integrated across all three components of the programme.

The UNFPA 6th CP has undoubtedly made a contribution to the significant progress Rwanda has made towards achieving its development goals and the MDGs for improving maternal health, gender equality and women’s empowerment, and in combating HIV, malaria and other diseases. The Maternal Mortality Rate has decreased from 1,071 per thousand live births in 2000 to an estimated 383 per thousand live births in 2008. The number of women delivery in a health facility increased from 31 per cent in 2000 to 29 per cent in 2010. The Total Fertility Rate (whilst still very high) decreased from over 6 in 2000 to 4.5 in 2010.

In terms of gender empowerment, Rwanda has the highest percentage of women in Parliament in the world (56.3%).

UNFPA has notably provided technical support for the development of the health sector strategic plan, research into maternal mortality and activities to reduce maternal mortality and provide obstetric fistula repair. It has supported advocacy and awareness-raising activities in sexual and reproductive health (SRH) for the community in general and especially for vulnerable groups. It has supported the establishment of secondary family planning posts near Catholic health centres and sensitised over 400 religious leaders on SRH.

A programme for former sex workers has been developed and implemented. A basic package for Youth Friendly Health Services (YFHS) has been developed as well as support for the operation of three YFCs and two clinics operated by ARBEF (the Rwanda Association for Family Welfare).

This evaluation considers that UNFPA support to the following areas has been “outstanding”: Maternal Death Audit; obstetric fistula care; Sex Worker Project; and the establishment of two One-Stop Shop Centres for gender-based violence (in Kigali and in Gihundwe Hospital in Rusizi district).

The short time span between the MTR and the End Line Evaluation (ELE) raises questions about the value of both exercises. Timing the ELE over a year ahead of the end of the programme adversely affects the relevance and scope of the evaluation.

**Programme alignment**

UNFPA adheres to the Paris Declaration and Accra Agenda for Action principles in providing support to government priorities in reproductive health, population and development, and gender, and supporting Implementing Partners (IPs) in their priorities. The UNFPA 6th CP is closely aligned with Government of Rwanda development goals has contributed to progress in achieving these goals. UNFPA has been able to focus on areas where it has a comparative strength and work with other UN agencies to deliver joint projects as part of One United Nations support to Rwanda. The Joint Gender Project seems to be working well, the Youth one less so.
Contribution analysis demonstrates that the aid UNFPA disburses in Rwanda makes a contribution to the achievement of Rwanda’s development goals, especially in the reduction in maternal mortality, increased use of modern contraception and increased deliveries in health centres. Three of the activities for which UNFPA provides technical and financial support were seen to be especially important by key informants - the former Sex Worker Project, the support for Youth Friendly Centres (YFCs) and the support for One Stop Centres for survivors of gender-based violence (GBV).

**Reproductive Health**

The main focus of the UNFPA 6th CP has been on providing technical support to improve RH care at central and local levels. UNFPA provides support to: 1. the Ministry of Health for the development and implementation of RH policies and strategies; 2. district hospitals to support the delivery of RH services; 3. districts to support community RH services; and 4. the National AIDS Council (CLNS) to support HIV policy development and implementation.

A significant contribution has also been made to the supply of RH commodities (such as, condoms and contraceptives) and for advocacy, awareness raising, and capacity building.

UNFPA has: contributed to the Maternal Death Audit programme which witnessed a notable decline in maternal mortality over a three year period and provided support for the 2010 Demographic Health Survey (DHS). Most recently UNFPA has contributed to the development of a policy for Youth Friendly Health Services.

At the decentralised level UNFPA provides technical support to district hospitals and large numbers of health workers have been trained as skilled birth attendants and in obstetric fistula prevention and care. Support has been provided for the training of Community Health Workers (CHWs) and at least two are in post in each village. Alongside this, widespread activities have been conducted in advocacy for contraception and condom promotion, efforts to reduce the total fertility rate, and the prevention of HIV and sexually transmitted infections (STIs). UNFPA has also supported a project for sex workers (including income generation) at one site and contributed to supporting the development of Youth Friendly Health Services in district hospitals.

Key informants highlighted the importance of the work UNFPA were doing in supporting former sex workers both by supporting the development of policy and through support to the project in Rubavu. This work supports efforts to reduce the spread of HIV and to enable vulnerable women to gain the skills for sustainable income generating activities.

The high incidence of gender-based violence (GBV) and the strong support of the government for work in this area indicate that UNFPA should continue its support for One Stop Centres.

The main shortcomings in the RH component are the lack of integrated sexual and RH services (including FP, HIV and STI prevention and treatment services) and cultural barriers to family planning. Greater attention needs to be paid to the unmet need for family planning through interventions to increase the age of marriage and first pregnancy, and to reduce the number of children that women have through increased access to contraceptive services.

**Population and Development**

The key focus of this component is support to Government, centrally and locally, in the collection and use of high quality disaggregated statistical data to inform policy formulation and implementation. UNFPA provides support to MINECOFIN for population issues and for monitoring and evaluation (M&E). Technical support has been provided for the development of the revised Population Policy (published in 2010 but yet to
be approved by Cabinet). Together with other UN agencies support is being provided to MINECOFIN to develop an M&E system for monitoring the implementation of EDPRS 2.

National support has been provided to MIJESPOC to develop Youth Friendly Centres (YFCs) and such centres have been supported in three districts. Emphasis should be placed on educational programmes for youth as part of the YFCs to promote the desired SRH behaviour. In addition to offering advice on SRH, the YFCs should provide youth with skills for income generation.

Also at the national level UNFPA has provided technical support and funded equipment for the NISR to conduct the 2012 Housing and Population Census which is on course to be completed on time. UNFPA has supported the development and implementation of a Civil Registration and Vital Statistics System which is now embedded at a national level. Support has also been provided for a management information system to enable access to national survey data via a web portal. The portal is operational and a number of surveys have been uploaded.

Technical support to NISR and MIJESPOC has been effective and is producing planned results.

At the decentralised level support is being provided to the five districts to be able to implement the Civil Registration and Vital Statistics System and in the collection and use in planning of high quality statistical data disaggregated by key groups. Whilst considerable progress has been made the districts still need significant support (technical and equipment) to develop fully functioning systems for data collection, analysis and use for planning. Some districts expressed concern that although they were appreciative of the support received from UNFPA it was currently inadequate for their needs.

**Gender**

The gender component is cross-cutting and UNFPA technical support is provided to the MIGEPROF and the Gender Monitoring Office (GMO), as well as awareness raising about gender amongst the Forum of Women Parliamentarians. Support to the GMO has been to develop systems for the collection and use of gender disaggregated data, although this is still in the early stages of development and there remains a significant need for technical support for gender mainstreaming and the collection and use of gender-disaggregated data nationally and at decentralised levels.

Much UNFPA support has been provided in collaboration with UNWomen and there has been a focus on gender-based violence (GBV) and gender mainstreaming across the public sector at central and de-centralised levels. UNFPA working with other UN agencies supports the One Stop Centres and the Agaseke Project in Kigali City. The One Stop Centres are important given the extent of GBV in Rwanda, as are the projects to enable vulnerable women to develop the skills for income generating work and thereby provide them with a sustainable livelihood.

Gender clubs in schools and higher education institutions have played a role in raising young people’s awareness of gender equality and the empowerment of women, RH and gender based violence.

**Young people**

In 2011, 20.5 per cent of the population in Rwanda are aged 15 to 24 years and have specific needs for the prevention of unintended pregnancy, HIV and STIs. A Behavioural Biological Survey (BBS) conducted in 2010 found that HIV prevalence had increased among young people aged 16 to 19 years in two areas of Kigali (Biryogo and Gikondo) and was 16 per cent compared with a national HIV prevalence rate of 0.5 per cent for young people in the 2005 DHS. Data from the 2010 BBS suggest that a low percentage (10.2%) of
youth aged 15-24 have a complete understanding of HIV risks. It was lower among those aged 15-19 years than those aged 20-24 years and among young women than young men. Condom use amongst young people who had had more than one sexual partner in the previous 12 months has increased for both young men and women since 2000. However the rates remain low with 58 per cent of young men and 29 per cent of young women saying they had used a condom in their last sexual encounter.

Young people therefore need increased access to sexual and RH services based on their needs. These services should be integrated into Youth Friendly Health Services (YFHS) and include contraception (for married and unmarried youth), counselling, HIV (VCT) and STI testing and treatment, and management of adolescent pregnancy.

**Responsiveness**

UNFPA is also highly valued in Rwanda because of its way of responding to the priorities of Implementing Partners, working with them to fund priorities within its mandate. UNFPA has been responsive to changing needs as they have become evident and has provided support for vulnerable groups, women and youth and for RH care in emergency situations.

**Monitoring and evaluation**

UNFPA has a sound results-based M&E (RBM&E) system, a M&E Officer is in post and progress is regularly reviewed with results feeding back into programme implementation. Implementing Partners have been trained in RBM&E, although there is clearly a need for further capacity building so they can monitor and evaluate projects they are implementing.

Whilst the M&E system is in place and operational some gaps remain, such as the absence of base line data, specified national and local target, SMART indicators and no risk analysis having been undertaken. Greater attention needs to be paid to the selection of indicators where data are available to measure progress and impact. Robust methods that enable the attribution of outcomes to specific inputs are not always appropriate for the activities that UNFPA funds, and there are challenges in having a robust set of SMART targets with baseline data and in collecting quality data at regular intervals. There is need to evaluate specific projects to measure the impact of UNFPA’s work - for example the former sex worker project, the YFCs and the health care centres supported by UNFPA. A good evaluation was conducted of the Maternal Death Audit Project.

**Efficiency**

The difficulty in measuring outputs and outcomes, due to inadequate baseline data and targets made it difficult to carry out a robust efficiency analysis. This was compounded by what seemed to be over-ambitious targets. The efficiency of the Reproductive Health component is acceptable, but the efficiency of the overall 6th CP is poor when the return on input to outcomes is measured. However, this is undoubtedly due to the lack of available data to measure progress against. Also it should be noted that the 6th CP still has over one year to run and it may be that efficiency will increase by then.

**Sustainability**

The main strength of the 6th CP in terms of sustainability is the synergy between Rwanda’s development priorities and the mutually consultative approach adopted by UNFPA. There is clear evidence of policies, programmes and projects becoming embedded in a number of areas where UNFPA provide support. Examples of this include the Maternal Death Audit, YFC, YFHS and One Stop Centres for GBV survivors. The CHW programme is clearly embedded and a key element of health care delivery.

The collection and use of quality statistical data and the establishment of the a Civil Registration and Vital Statistics system at
district level still has some way to go. There is still significant need to build capacity in the implementation of gender mainstreaming and the collection and use of gender disaggregated statistical data.

Sustainability remains a challenge in a country that depends on aid for half its budget and where there is a shortage of skilled and competent labour. The high turnover of employees in IPs means that technical support for capacity building does not always build the capacity of the organisation in the long term. Technical support and commodity provision are still needed to develop a sustainable national programme and IPs stated that if UNFPA withdrew funding then they would have to seek funding from elsewhere. The use of contraceptives may be less strongly embedded with religious leaders still able to influence couples not to use them and a concern that use may decline if they were no longer provided free.

Conclusions
The government is reviewing EDPRS 2008-12 and EDPRS 2 will be implemented from June 2013. UNFPA should ensure that it aligns the 7th CP with the priorities identified in EDPRS 2. UNFPA should also continue to work with IPs to identify priorities in line with UNFPA’s mandate and use the findings from the 2010 DHS when they are available to redefine priorities and redirect funds.

Our recommendations focus on priorities for the 7th CP to UNFPA. We have incorporated the findings of strengths and weaknesses in the 6th CP into our recommendations for the 7th CP. UNFPA should continue to provide technical assistance, fund reproductive health commodities and support advocacy, awareness raising and capacity building in reproductive health and population and development.

Examples of good practice in the Sex Worker Project, the Fistula Prevention and Treatment Project and One-stop shop Centres for GBV should be built upon. A survey of the need for such services should be conducted and services scaled-up accordingly with staff capacity build and standards of care, supervision and monitoring systems developed.

Efforts need to be intensified with existing sex workers as they were reported to have a 51% HIV prevalence rate in 2010 coupled with inconsistent condom use.

The lessons learned from the 6th CP indicate that UNFPA should take a more focussed approach and concentrate on doing a fewer things well so that it makes a difference and can demonstrate impact. UNFPA should prioritise and focus interventions to those areas where it has a comparative advantage at both central and decentralised levels. Consideration should be given to further reduce the number of districts worked in as district staff expressed concern about the adequacy of funding. Whilst becoming even more focused UNFPA should nevertheless remain responsive to emergencies and emerging government priorities and continue to focus on vulnerable groups.

A continued focus on vulnerable groups is important as preliminary findings from the 2010 DHS together with data from Biological Behavioural Surveys suggest that whilst most people know about HIV and safer sex, the increase in at-risk populations adopting these behaviours is disappointing and is below target.

Youth Friendly Health Services could be at stand-alone clinics, or services made available on special days at the health centre or health posts. Irrespective of how these YFHS are organized logistically, there need to be nationally agreed norms and standards of care developed in conjunction with young people and health service providers. Alongside this, YFHS staff will need to be trained in delivering quality YFHS and a monitoring system established to assess the appropriateness and acceptability of the services for young people.
It is also important to sensitize CHWs to the special needs of youth and adopt a non-judgmental approach.

UNFPA should also consider how it can foster South-South cooperation in the 7th CP.

The promotion of public-private partnerships (PPP) for family planning needs to be intensified to ensure sustainability of RH commodities (condoms and contraceptives).

Improved indicators consistent with UN global indicators (such as, the UN General Assembly Special Session (UNGASS) Core Indicators on HIV) are called for in the 7th CP and UNDAF. Support should be provided to projects for the identification of appropriate indicators to measure progress to achieve outputs and outcomes and use these as an integral element of M&E.

The design of the programme should identify alternative explanations for anticipated changes and incorporate contributory analysis into monitoring and evaluation activities.

Building national capacity in M&E and the provision of specific technical support to the national Civil Registration and Vital Statistics System and the collection of disaggregated data for RH, population and development should be continued.

Cost effectiveness and contributory analyses should be built into the UNFPA M&E Framework from the outset. A risk analysis of the 7th CP should be carried out when it is drafted and strategies for overcoming the risks identified developed. A theory of change that enables the identification of the preconditions for achieving outputs and outcomes, especially as they relate to behaviour change, should also be developed.
Recommendations to UNFPA

**Priority 1:** Align UNFPA 7th Country Programme with Rwanda’s development priorities and needs as set out in *EDPRS 2* and District Development Plans.

**Priority 2:** Focus the interventions so that UNFPA’s investment makes a difference and there is real impact.

**Priority 3a:** Focus on young people to change their fertility behaviours through delayed first sex, reduction of pregnancy amongst adolescent girls, preference for a smaller family size, and continued access to a range of male and female contraceptive methods.

**Priority 3b:** Focus on the prevention of HIV and sexually transmitted infections amongst male and female youth in the five districts.

**Priority 3c:** Integrate sexual and RH services for young people in Youth Friendly Health Services (YFHS), develop national norms and standards for YFHS and build capacity of staff to offer quality services appropriate to the needs of young people.

**Priority 4:** Continue to provide support for the Sex Worker Project nationally and in Rubavu and Kigali following a review of the work to date and develop a strategy for scale-up of services provided. Focus in the future on the regular partners and male clients of sex workers and promote condom use amongst them.

**Priority 5:** Continue to provide support for the obstetric fistula care project and develop a strategy for scale-up of services to ensure that all women who need fistula repair are able to receive it.

**Priority 6:** Continue to support the One-stop shop Centres in Kigali and in Gihundwe Hospital and scale-up GBV services so they are available throughout Rwanda and build capacity of staff as required.

**Priority 7:** Continue to advocate and raise awareness for RH and population and development, paying specific attention to the unmet need for family planning and ensure that staff capacity is build and commodities are available to support these services from a range of public and private sector providers.

**Priority 8:** Continue work with the districts to further develop capacity for the collection and use of statistical data in planning and establish and operationalize the Civil Registration and Vital Statistics System.

**Priority 9:** Continue to support the National Institute of Statistics, Rwanda and the Gender Monitoring Office to collect and analyse population data to inform policy development and implementation with an emphasis on the collection of gender disaggregated data.

**Priority 10:** Strengthen the monitoring and evaluation system through the identification of appropriate indicators that are consistent with UN global indicators. Continue to strengthen UNFPA internal capacity and the capacity of its implementing partners in monitoring and reporting results, including efficiency and Contribution Analysis.
Recommendations to the Government, Implementation Partners and the United Nations

1. The government should facilitate the process of UNFPA support to government priorities in order to add value to the implementation of EDPRS2.

2. Districts should clearly identify priorities for funding with UNFPA to enable them to fully develop and implement the systems for collecting and using statistical data including the vital registration system.

3. The Population Desk in the MINECOFIN in collaboration with UNFPA should identify the technical support required from UNFPA to implement the Population Policy once Cabinet approval has been granted.

4. The National Institute of Statistics, Rwanda should appraise UNFPA of the technical support required under the 7th CP to improve the vital registration system and use of disaggregated data for planning and monitoring.

5. CNLS should agree with UNFPA how the former sex worker programme and HIV interventions with most at-risk young people can be taken forward and scaled up and identify areas where UNFPA technical support is required.

6. The Ministry of Health should develop an implementation plan for Youth Friendly Health Services and identify areas where UNFPA technical support is required.

7. The Ministry of Health should develop an implementation plan for scaling up the Obstetric Fistula programme and identify areas where UNFPA technical support is required.

8. The Ministry of Health should develop an implementation plan for scaling up GBV services so they are available throughout Rwanda and identify areas where UNFPA technical support is required.

9. The UN Agencies in Rwanda should continue to identify areas where they can work together to support to the government of Rwanda in reproductive health and population and development, including taking forward areas where there is existing collaboration.

10. The UN should consider how it can further ensure collaborative working between the various agencies to reduce transaction costs especially in the health sector.
1. Introduction and methodology

1.1. Background
This report focuses on the contribution of the UN Population Fund (UNFPA) in Rwanda to the achievement of national priorities and global goals relating to: participation in democratic governance; gender equity; reproductive health (RH), population and nutrition; HIV; education; and sustainable growth and social protection (in this context economic empowerment of disadvantaged women, disaster management and reduction in gender-based violence, GBV).

UNFPA originally provided support in 14 districts for RH and family planning (FP) services and the collection and use of statistical data for planning, but following the Mid Term Review (MTR) recommendations in 2010 the focus was reduced to five districts in the Western Province. A major element of UNFPA support is technical advice and support nationally and at district level.

The UNFPA 6th Country programme (CP) was approved by the Executive Board of the United Nations Development Programme (UNDP) and of UNFPA on the 12th October 2007 with a budget of US$ 30 million. This was a significant increase on the funding available under the 5th CP which amounted to an original budget of US$ 7 million and a disbursement of US$ 8.1 million (Akoto et al. 2007).

1.2 Purpose
The purpose of the assignment was to carry out an independent End Line Evaluation (ELE) of the UNFPA Rwanda 6th CP January 2008 – June 2013 to complement the MTR carried out in 2010 by the UNFPA Country Staff with the support of a team of consultants. The End Line Evaluation considers the results to date (based on data available as of September 2011) and assesses (wherever possible) the extent to which the expected results are likely to be achieved through trend analysis. The emphasis is on the impact of the 6th CP on the lives of ordinary citizens of Rwanda and the achievement of the country’s development goals and the MDGs. The findings and the lessons drawn from the evaluation will inform the development of the 7th CP.

1.3 Expected Outcomes
This report addresses the main questions specified in the Terms of Reference (Annex 1) - that is, to assess the:

1. **relevance** of the programme to Rwanda’s national development priorities, to the achievement of United Nations Development Assistance Framework (UNDAF) priorities and to solving the identified problems and needs of beneficiaries;

2. **effectiveness** of the programme in terms of meeting the planned objectives, the engagement of the Country Office (CO) in United Nations (UN) reform processes and in upstream and downstream work, the joint programme modality contributing to the achievement of the UNFPA Strategic Plan (SP) results and the coordination mechanisms contributing to the achievement of the expected results;

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3 UNFPA operates part of the UN family under the Delivering as One (DaO) approach in Rwanda.
4 The 6th CP was scheduled to run from 2008 to 2012, but has been extended to June 2013 at the request of the Government of Rwanda so the UN Programme Cycle fits with the Government fiscal year which has been changed to harmonise with the other members of the East African Community.
5 The Annual Report on the Implementation of the EDPRS 2010-11 was not available at the time of writing, although it was due to be published in October 2011.
3. **efficiency** of the programme in terms of results versus inputs, gender mainstreaming being addressed in the design and implementation of the 6th CP, the cost effectiveness and efficiency of the implementation strategies and the efficiency of the process and systems used including the application of results based management in achieving CP results;

4. **contribution** of the programme to the intended outcomes;

5. **impact** of the implementation of the programme in terms of changes for beneficiaries;

6. **sustainability** of the programme and capacity of the implementing partners and Government to scale up programme activities. Sustainability of the progress and achievements made and ability to scaled up and maintain positive changes brought about by interventions.

In summary, the ELE Report:

- documents the achieved results to September 2011 and provides a trend analysis for predicted results to June 2013 wherever possible;
- identifies the main challenges encountered;
- specifies the lessons learnt;
- recommends alternative cost-efficient strategies to be used by UNFPA and implementing partners in the 7th CP and identifies the areas of UNFPA’s comparative advantage that the CO should focus on in the 7th CP in the context of the new aid environment and the DaO approach.

The ELE Report is divided into eight chapters: 1. Introduction and methodology; 2. Country context and the policy framework that informs the UNFPA 6th CP; 3. An overview of the UNFPA 6th CP; 4. Main findings and the relevance, effectiveness, impact and sustainability of the programme; 5. Strategic positioning and contribution to results of the 6th CP; 6. Monitoring and evaluation; 7. Efficiency of the 6th CP; 8. Conclusions and Priorities for the 7th CP.

### 1.4 Methodology

#### 1.4.1 Introduction

The independent ELE was conducted during September and October 2011 by a team of researchers from the University of Aberdeen in Scotland and researchers from the Institute of Policy Analysis and Research (IPAR) in Rwanda.

Programme evaluation is designed to provide an account of output, action and process. While outputs are the direct result of the activity, outcomes are the changes that come about as a result of the programme. Evaluation is the assessment of the outcomes against the programme's objectives – in this instance, an assessment of whether or not the 6th CP has achieved what it set out to. Evaluation is different from monitoring, which is concerned with ensuring that the programme is making satisfactory progress towards the targets set and the assessment of day-to-day performance.

#### 1.4.2 Objectives and Scope

The evaluation covered all the interventions, including joint projects, for the three main components, RH, PD and gender equality from 2008 to September 2011 (although in practice data is only available up to 2010) together with a trend analysis to December 2012. The specific objectives of the evaluation are shown in Annex 1.

#### 1.4.3 Evaluation Methods

The research methods used included desk research, questionnaires, in-depth interviews, focus group discussions (FDGs) and observation.
The evaluation used both quantitative and qualitative research methods, combining the strengths of both and triangulating findings wherever possible. Quantitative methods, using available indicators for at least three points in time including for 2008 (or just before) and for 2010, enabled a trend analysis to be carried out. Indicators for data that are available for 2008 or just before and for 2010 permit measurement of progress, but a trend cannot be inferred from data for which only two measurement points are available. The strength of time series quantitative data is that it enables precise measurement. Other qualitative data that can be collected, for example, are the absence or presence of a policy or programme or the number of clients using a service.

Qualitative data are of two types: data collected using structured questions that ask for quantifiable value judgements, and in-depth data collected through agenda/open interviews and focus group discussions. The latter enables a much richer and detailed understanding of informants’ views, attitudes and understanding. Qualitative data from this type of research can illuminate and illustrate quantitative data and provides an understanding of informants’ views about the quality of services. However, unless there are baseline qualitative data available it is difficult to determine what has changed as people’s memories can be unreliable.

**Desk Research:** This involved reviewing all relevant documents, including key UNFPA documents, government policies and programmes. The most up-to-date statistical data for assessing progress were collected. The key sources of data identified were the 2008 *Interim Demographic and Health Survey* (IDHS) and the preliminary findings from the 2010 *Demographic and Health Survey* (DHS), the Health Management Information System (HMIS), data from the Treatment and Research AIDS Centre (TRAC) and the Rwanda Biomedical Centre, budget statements, *Economic Development and Poverty Reduction Strategy* (EDPRS) Monitoring and Evaluation (M&E) Reports and District Performance Contracts. All the documents and literature reviewed during the course of the evaluation are referenced at the end of the report.

**Field Research:** included semi-structured interviews with key informants, stakeholders and beneficiaries and FGDs with key informants and beneficiaries. Field research took place both in Kigali and in a purposive sample of five districts outside of Kigali where UNFPA funds activities.

All interviews and FGDs were carried out by members of the research team trained in using the tools and familiarised with the purpose of the evaluation. Trained note takers made detailed notes and on return to the office they word-processed them in preparation for analysis.

Interviews were conducted in a language agreed between the researcher and the informant. It was assumed that key informants and stakeholders would be able to answer questions in English and beneficiaries in Kigali and that District Officers would prefer to answer in Kinyarwanda. Members of the research team were competent in English, French and Kinyarwanda. All data collection tools were prepared in English.

**Data Collection Tools included:**
1. Key informant interview schedules;
2. Key informant focus group discussion (FGD) guides;
3. Stakeholder interview schedules;
4. Beneficiary interview schedules;

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6 Interviews were either with individuals or groups.
5. Beneficiary FGD guides;
6. Information to be collected from UNFPA, partners, government offices, districts, non-governmental organizations (NGOs), faith-based organizations (FBOs) and civil society organizations (CSOs) (see Annex 7).

Agendas for FGDs and interview schedules were developed based on the analysis of the material collected for the desk research as relevant to each agency.

**Sampling:** was purposive and included UNFPA officers, central and local government officials, staff and beneficiaries of non-governmental organizations (NGOs), faith-based organizations (FBOs) and civil society organizations (CSOs) both in and outside Kigali (see Table 1). The five districts and District Hospitals (DHs) were those UNFPA is working in (Karongi, Ngororero, Nyamasheke, Rubavu and Rusizi) and two from which they are withdrawing (Nyagatare and Rwamagana). The list of persons interviewed as part of this evaluation is shown in Annex 2.

<table>
<thead>
<tr>
<th>Institutions</th>
<th>Number of people interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNFPA</td>
<td>3 + 1 FGD</td>
</tr>
<tr>
<td>UN</td>
<td>3</td>
</tr>
<tr>
<td>Central Government</td>
<td>9</td>
</tr>
<tr>
<td>Rwanda Association of Local Government Authorities (RALGA)</td>
<td>1</td>
</tr>
<tr>
<td>Districts</td>
<td>5</td>
</tr>
<tr>
<td>District Hospitals</td>
<td>7</td>
</tr>
<tr>
<td>YFC Managers</td>
<td>2</td>
</tr>
<tr>
<td>Parliament</td>
<td>4</td>
</tr>
<tr>
<td>Official Development Partners (ODPs)</td>
<td>1</td>
</tr>
<tr>
<td>NGOs</td>
<td>3</td>
</tr>
<tr>
<td>Beneficiaries</td>
<td>6 FGDs</td>
</tr>
</tbody>
</table>

**Efficiency Analysis:** A cost efficiency analysis was carried out.

**Contribution Analysis:** A contribution analysis was conducted by producing a plausible ‘performance story’ which provides a reasoned assessment of the contribution of the programmed interventions to the outcomes.

**Data analysis:** The key informant interviews and the FGDs were analysed thematically. Although it was a small sample there was a significant amount of agreement in the responses from different key informants and from FGDs with beneficiaries. Information from the fieldwork complemented information and data in the resource file provided by UNFPA. For example, a fieldwork report in the data file indicated that young people who attended Gender Clubs had a good understanding of sexual and reproductive health (SRH). This evaluation found that young people who attended a Youth Friendly Centre (YFC) also had a good understanding of SRH. Fieldwork findings also complemented information in the data file. For example, the data file provided information on the programme for former sex workers and data from the fieldwork described the positive impact the programme had had on their lives.

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7 At the outset of the 6th CP UNFPA worked in 21 Districts, but from 2011 the focus was reduced to five and UNFPA withdrew from the others apart from continuing to support a Youth Friendly Centre in Gicumbi.
The fieldwork also enabled us to see the links between different elements of policy. For example, women told us about the positive support they receive from Community Health Workers (CHWs) in terms of access to contraception which they would not be able to use if they had to pay for it. The fieldwork also provided information on the extent to which interventions were having an impact. For example, the District Officials explained to us the financial and logistical constraints they confronted in getting the vital registration system up and running.

**Ethical Considerations:** All those asked to participate in the research were informed about the purpose of the evaluation and why they were asked to participate. They were informed that they had the right to refuse to participate and could withdraw at any time. All data are anonymous and no individual can be identified in any reports or other publications arising from the evaluation. All questionnaires, interview transcripts and FGD notes have been stored in a secure location.

**Ethical Approval:** The research was subject to ethical scrutiny through the procedures of the Institute for Policy and Research (IPAR)-Rwanda.

**Gender:** Gender considerations and cultural sensitivities were taken into account throughout the research process and particularly in relation to FGD and beneficiary interviews. The consultancy team included three male and three female members and wherever possible female beneficiaries were interviewed by female members of the team.

**1.4.4 Limitations**

There are three main issues that confront impact analysis: i. the availability of good baseline data; ii. the problem of attributing the outcomes achieved to the inputs by UNFPA and of demonstrating a causal relationship; and iii. the counterfactual problem, the difficulty of knowing what would have happened if external aid had not been provided.

Several limitations impact on the validity, reliability and utility of the findings:

1. The period of implementation was short and significant change after three and a half years is unlikely;
2. The *ELE* was carried out over a year ahead programme completion as originally scheduled and just over three and half years into what has become a five and half year programme;
3. The programmes and interventions funded by UNFPA were often conducted in collaboration with other agencies and it is not possible to say with certainty that the interventions by UNFPA are solely responsible for specific improvements/outcomes;
4. A number of the impact indicators are influenced by a range of factors - legal, policy and programme interventions - unrelated to UNPA programme interventions. It is not possible to estimate the possible contribution of UNFPA to some observed improvements;
5. Quantitative data available to measure improvements were limited and often not recent. The last household survey was in 2006 and only preliminary findings are available from the 2010 DHS;
6. The adoption of a law or the introduction of a policy on its own does not necessarily lead to its full implementation, nor does it necessarily improve the quality of the legal/policy framework;
7. The judgment as to whether a policy or programme is gender-sensitive is subjective unless a full gender impact analysis has been carried out;
8. It was not possible to conduct a full cost-effectiveness analysis with the data available;
9. Contribution analysis is a new approach to evaluation and the methodology is not well developed and should be built into programme monitoring and evaluation (M&E) from the outset.
2. Country Context and Policy Framework

2.1 Country Context
Rwanda is the most densely populated country in sub-Saharan Africa, with about 470 people per square kilometre and a population of just under 11 million. Over 80 per cent of the population live in rural areas and are dependent on subsistent agriculture. Poverty remains high (56.7 per cent in 2005/6), especially in rural areas and is lowest in Kigali city.

Significant progress has been made in overall development in the last decade. Economic growth has been maintained in real terms since 2002. The average annual growth rate in gross domestic product (GDP) between 2005 and 2009 was 8.8 per cent and GDP per capita income increased from under US$ 200 per capita in 1994 to 540 US$ in 2010. However, there has also been a growth in inequalities with the Gini coefficient increasing between 2000 and 2006 from 47 per cent to 51 per cent.

Good progress is being made towards achieving the MDGs, especially in education, gender and health. The Overseas Development Institute (ODI) recently highlighted significant improvements in health status in Rwanda and the mutual health insurance scheme and Community Health Workers were highlighted as examples of good practice.

2.2 Rwanda’s Development Goals
In 2000 the Republic of Rwanda outlined its vision for its future as:

“A modern and prosperous Nation, strong and united, worthy and proud of its fundamental values; politically stable, without discrimination amongst its sons and daughters; and all this in social cohesion and equity.” (Ministry of Finance and Economic Development, 2000)

The Economic Development and Poverty Reduction Strategy 2008-12 (EDPRS) is the key development policy for Rwanda and was designed to guide development during this period. The Strategy aims to achieve economic growth and transformation, promote good governance and improve the lives of ordinary Rwandans. It is grounded in a human development approach with a commitment to achieve the UN Millennium Development Goals (MDGs) by 2015. Gender, HIV/AIDS, environment, youth and social inclusion are cross-cutting issues. The UNFPA 6th CP was designed to be in alignment with it.

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*Data from the 2010 household survey are not yet available, but there seems little likelihood that the MDG target for poverty reduction will be met, despite a reduction in extreme poverty (Abbott and Rwirahira 2011; Vinck et al 2009).*

The institutional framework to monitor EDPRS involves the government, development partners, international and national NGOs and CSOs and the private sector. The EDPRS Results and Policy Matrix is organised around three major strategic objectives: i. increased economic growth; ii. managing the population growth rate and iii. enhancing good governance and enhanced gains through good governance.

2.3 Democratic Governance

Rwanda has achieved political stability (Figure 2), with a new constitution approved in 2003 and two rounds of Parliamentary and Presidential elections being held without serious incident.


The Millennium Challenge Corporation score card for Rwanda for 2010 indicated that on the ‘Ruling Justly’ criteria it scored green (above the mean for the peer group) on three criteria (control of corruption, government effectiveness, rule of law) and red on three (political rights, civil liberties, voice and accountability) (Millennium Challenge Corporation, 2010).

Rwanda has a Presidential system of government with two Houses of Parliament, the Senate and the House of Representatives. There is a separation of powers between the judiciary, the legislature and the executive, although Parliament is seen as weak in relation to the Executive. The Constitution champions a pluralistic politics defined by ‘dialogue and consensus’ mandates that 30 per cent of parliamentary seats shall be held by women and provides for representation of youth and people living with disabilities. Rwanda is one of only two countries in the world to have achieved the MDG Target of 50 per cent representation of women in Parliament. The representation of women at local levels has increased significantly during local elections in 2010.

Rwanda began a process of decentralisation in 2000 (Ministry of Local Government, Good Governance, Community Development and Social Affairs, MINALOC, 2000) to improve service delivery and make government more accountable. District Councils (of which there are 30) are directly funded from the National Budget and by donors and are able to raise local taxes to enable them to deliver services to their population. They report to the Government through the MINALOC. Every year, following a consultative process with their electorate, districts develop annual targets in line with Vision 2020 and EDPRS. They sign a performance contract with the President which is reviewed at the end of the year in a public ceremony. This has resulted in more a focused effort by districts and

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10 Data in percentile rank ranging from 0 lowest to 10 highest.
11 Political stability and absence of violence measure the perceptions of the likelihood that the government will be destabilised or overthrown. Government effectiveness captures perceptions of control of public services. Regulatory quality captures perceptions of the ability of the government to formulate and implement sound policies and regulations that permit and promote private sector development. Rule of law captures perceptions of the extent to which agents have confidence in and abide by the rules of society, especially the quality of contract enforcement, property rights and the courts, as well as the likelihood of crime and violence. Control of corruption captures the extent to which public power is exercised for private gain including petty and grand forms of corruption as well as ‘capture’ of the state by elites and private interests.
proved an effective mechanism for monitoring and evaluating performance (Ministry of Finance and Economic Planning, 2011).

Citizens report that they are generally able to participate actively in local decision-making and that local government is responsive to their needs and listens to their priority concerns. Satisfaction scores across the country range from 65 per cent to 84 per cent (Ministry of Finance and Economic Planning, 2011).

2.4 Role of External Assistance and Aid Policy

2.4.1 External Assistance

Rwanda is heavily dependent on Official Development Assistance (ODA) with around 50 per cent of the budget coming from aid\(^{13}\). The aid architecture is complex with aid fragmentation due to the number of donors, bilateral and multilateral agencies and international organizations. The total ODA to the Government sector under the financial year 2009/10 Development Partners’ Assistance Framework was US$ 934 Million (Figure 3). However, not all ODA is ‘on budget’ or even recorded in the Development Assistance Database (DAD) and it is difficult to estimate the amount of ‘off budget aid’ received. Overall ODA has been increasing, with about half coming from bilateral donors and half from multilateral donors. Private aid flows have also increased. Net ODA as a proportion of Gross National Income (GNI) is around 20 per cent (Figure 3; Table 2).

![Figure 3: Net ODA Receipts at 2008 Prices in US$ Million](http://stats.oecd.org/Index last accessed 02.10.2011)

<table>
<thead>
<tr>
<th>Year</th>
<th>Receipts (US$ Million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>577</td>
</tr>
<tr>
<td>2006</td>
<td>589</td>
</tr>
<tr>
<td>2007</td>
<td>722</td>
</tr>
<tr>
<td>2008</td>
<td>933</td>
</tr>
<tr>
<td>2009</td>
<td>934</td>
</tr>
</tbody>
</table>


Table 2: Aid Receipts 2007-2009

<table>
<thead>
<tr>
<th>Receipts</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net ODA (US$ millions)</td>
<td>722</td>
<td>933</td>
<td>934</td>
</tr>
<tr>
<td>Bilateral Share (gross ODA)</td>
<td>52%</td>
<td>48%</td>
<td>56%</td>
</tr>
<tr>
<td>Net ODA/GNI</td>
<td>21.3%</td>
<td>1.1%</td>
<td>8.7%</td>
</tr>
<tr>
<td>Net Private Flows (US$ millions)</td>
<td>4</td>
<td>10</td>
<td>81</td>
</tr>
</tbody>
</table>


Eighteen Overseas Development Partners (ODPs) provide aid to Rwanda and trend data on aid are available for 16 of them (Figure 4). The main sources of ODA have remained unchanged since 2005, with multilateral donors and consortia (African Development Bank, European Commission and the World Bank) accounting for the largest share, with the rest coming from bilateral donors. The UN is the eighth largest donor (Ministry of Finance and Economic Planning, 2010b).

A major concern is that much donor assistance has been poorly aligned with the Government’s priorities, limiting the impact on poverty reduction and economic development (Ministry of Finance and Economic Planning, 2007).

\(^{13}\) Data supplied by MINECOFIN November 2011
2.4.2 Aid Policy

There is a strong commitment by the Government of Rwanda to achieve the principles of the *Paris Declaration on Aid Effectiveness* and the *Accra Agenda for Action*. There are four main elements to the agenda:

- Ownership by partner countries;
- Alignment with partner countries’ agendas and use of their systems;
- Harmonization between donors;
- Mutual accountability between donors and partners, including citizen accountability and the involvement of Parliament and civil society.

The *Aid Policy* (Ministry of Finance and Economic Planning, 2006) sets out the Government’s expectations for the management and use of aid in support of the *EDPRS*. It goes beyond the Paris commitments and is adapted to the situation in Rwanda. Development partners are expected to align aid with Government priorities, and provide technical assistance through national systems. The Development Assistance Database is used to report aid flows and rules for the settlements of disputes have been developed. The Government wants: all aid to be ‘on budget’ and ‘on plan’; increased use of government systems in the delivery of aid; donors to make use of their comparative advantage at sectoral level; and joint missions to reduce transaction costs. The Government has a preference for general budget support, followed by sector budget support. Stand-alone projects are expected to be on budget and to plan. Pooling of project funds is encouraged.

Rwanda is one of only two countries awarded an A grading by the Office of European Development Cooperation (OECD) review of progress towards achieving the *Paris Declaration on Aid Effectiveness* ahead of the Busan meeting in November 2011 (OECD, 2011). Rwanda has been singled out as an example of a programme

“...entirely rooted into the national development strategy with a strong commitment by the central government. This has led donors to harmonise and align themselves to the position of the Government, keeping a role but avoiding fragmentation”. (European Commission, 2011: 83).
The key objectives of the Aid Policy are:

- operational development strategies aid flows aligned with national strategies and clear linkages between EDPRS, sector strategies, the budget, the Medium Term Expenditure Framework and District Development Plans;
- reliable country systems and the use of these country systems by donors;
- strengthened local capacities by coordinated support;
- avoidance of parallel implementation units;
- ensuring aid is more predictable.

New initiatives following the introduction of the Aid Policy include:

- an annual retreat of development partners;
- Development Partners’ website which provides a forum for information-sharing;
- Development Assistance Database (DAD), which seeks to capture significant aid flows;
- annual reports on aid effectiveness which set out targets and a wide range of deliverables (Common Performance Framework; Joint Governance and Assessment Framework);
- Donor Division of Labour in Rwanda, agreed in September 2010, defines which donors will be active in each sector to reduce transaction costs and ensure a more even spread of donor activity across EDPRS priorities.

2.5 Health Policy and Service Delivery

2.5.1 Health policy

The Health Sector Strategic Policy is operationalized through the Health Sector Strategic Plan 2009-2012 which is also aligned to the EDPRS (Ministry of Health, 2009a). Health delivery is provided through community health services, health posts, health centres, district hospitals and referral hospitals. Health services are provided by the Government, NGOs, FBOs and the private sector. Funding for health comes from the Government budget, aid, other charitable sources of funding, health insurance and fees/charges.

The government has allocated between nine and 10 per cent of its budget to health in recent years in line with the EDPRS target of 9.2 per cent. This is below the target of the New Partnership for Africa’s Development (NEPAD) of 12 per cent and of the Abuja Declaration (15%) (Ministry of Health, Maternal Child Health, 2011a). In 2008, health expenditure was 10.3 per cent of GDP of which 4.8 per cent was from government and 5.5 per cent private. External funds accounted for 52 per cent of health care spending and health care spending was US$ 37.3 per capita.

Globally, the distance to a health facility has been shown to be related to maternal and child health and survival (Say and Raine, 2007). In Rwanda around 23 per cent of the population live more than an hour’s (5 kilometre) walk from a health facility (HMIS, 2009).

There is a universal system of mutual health insurance with membership growing rapidly between 2003 and 2009. The 2011-12 Budget introduced a graduated payment system for community health insurance with free services for the poorest (Figure 5). Pregnant women who attend four antenatal care visits are exempt from paying the ‘ticket moderature’ - the small sum of money paid at the point of delivery for health care.

Another important innovation for improving health is the system of Community Health Workers (CHWs). Each village has two CHWs, one male and one female, who are elected by the village. They are trained to provide health promotion and basic health care. They play an important role in encouraging and supporting women to use RH services, including contraception, antenatal care and delivery in health centres. A recent innovation has been the trial of Rapid Short Message Service (SMS) whereby CHWs are provided with a specially programmed mobile phone so they can contact the hospital and arrange for an ambulance in an emergency. The training of CHWs in maternal and new born care began in 2010 and by the end of June 2011 they had been trained in eight districts. In 2010, 27 per cent of pregnant women were accompanied by a CHW to a health centre for delivery. This varied from a high of 50 per cent in Nyamasheke (one of the districts in which UNFPA is working) to just over 10 per cent in Kamonyi (Ministry of Health, 2011). Recognising the fragility of a system based on elected volunteers the Ministry of Health has introduced two schemes to incentivise/reward CHWs. The first is an in-kind incentive scheme with female CHWs eligible to receive an incentives package dependent on meeting targets for maternal health care. The second is organising CHWs into worker cooperatives so that they can generate income to support themselves and their households (Ngabo and Humuza, 2010).

The Government aims in the health sector to achieve a Sector Wide Approach (SWAp) with one plan, one budget and one report for health (Ministry of Health, 2009a; Terwindt, 2010). The health sector developed a SWAp in 2004 which was launched in 2007, with all partners including the UN signing a Memorandum of Understanding (MOU) in 2008. The SWAp is to enable alignment and harmonization, strengthen Ministry of Health (MINISANTE) leadership, increase efficiency and effectiveness, and improve transparency and mutual accountability. The SWAp is still evolving, but has moved well towards donors being ‘on plan’. However, the majority remain ‘off budget’ with about 80 per cent of health funding being ‘off budget’15. Most donors use government systems and the number of parallel implementing units has reduced (Terwindt, 2010). There remain some significant funders of health who are ‘off budget’ and use Project Implementation Units (PIU) for example, the United States President’s Emergency Plan for AIDS Relief (PEPFAR).

### 2.5.2 Reproductive health

Rwanda has made tremendous strides in achieving the RH targets it set itself, even though the largest funding gap in the health sector is in the maternal and child health/family planning (FP)/RH programme areas (Ministry of Health 2009). For example, the maternal mortality rate has decreased from 1,071 per thousand live births in 2000 to an estimated 383 per thousand live births in 2008 (Figure 6; Maternal Health Department, 2011). This makes the 2012 EDPRS and 2015 MDG targets look possible, and indicative figures for the HMIS suggests that the rate has declined

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15 There seems to be some confusion amongst ODPs between aid flows being reported to the DAD and using government systems and being ‘on budget’. To be ‘on budget’ the funds have to be reported to the MINECOFIN and be included in the Finance Bill.
rapidly since 2008. More reliable figures from the 2010 DHS will be available later in 2012. In the absence of reliable maternal mortality data, trends in antenatal, delivery and post-delivery care can be used as indicators of the likely trend in maternal mortality (Jararaman et al., 2008). There has also been an increase in deliveries attended by a skilled birth attendant since 2008.

Maternal death audit has made an important contribution to reducing maternal mortality. It was introduced in 2008 and an evaluation carried out in 2011 found a significant overall decline in the maternal death rate between 2008 and 2010 in the hospitals participating in the trial (Ministry of Health, 2011). The decline was due to a reduction in deaths from ante-partum haemorrhage and post-partum haemorrhage. The authors of the evaluation note the need to continue to invest in technical capacity building and to implement community death audits.

The number of women delivering in a health facility had increased to 69 per cent by 2010 compared with 53 per cent in 2008 and 39 per cent in 2005 (Figure 7). The Government target of 95 per cent of women being attended by a skilled birth attendant by 2015 could be met with intensified effort.

The Health Management Information System (HMIS) data on the proportion births taking place in a health facility in 2010 shows wide variation by district: from 80 per cent in Huye to about 34 per cent in Kamonyi. However, these figures should be treated with caution as they cover only government health facilities and accurate estimations of district populations are not yet available (Maternal Health Department, 2011).
The vast majority of maternal deaths occurred in district hospitals.\(^{16}\) Nearly 40 per cent of complications occurred in the post-partum period (38.5%), 30 per cent were due to complications of pregnancy and 29 per cent due to complications during childbirth (Ministry of Health, 2011). It has been recommended that emergency obstetric services be increased together with improved transportation to health facilities. The Rapid SMS has been designed to facilitate this.

Antenatal care is important for reducing maternal mortality and morbidity. Over 90 per cent of pregnant women attend for at least one antenatal care visit, but despite some improvements in recent years only just over a third of women attend the World Health Organization (WHO) recommended four visits (\textbf{Figure 8}), and in 2008, 33 per cent of women delayed their first visit until the 6/7 month of pregnancy. It has been reported that “women delay in seeking antenatal care early in pregnancy due to cultural norms which discourage talking about pregnancies before they are ‘obvious’” (Ministry of Finance and Economic Planning, 2010: 27).

\textbf{Figure 8: Antenatal care visits 2008 and 2010}

![Antenatal care visits chart]

Sources: Ministry of Health et al, 2009; Ministry of Health et al, 2011

Improvements in maternal health can also be linked with women tending to have fewer children because of an increase in contraceptive use (\textbf{Figure 9}), and a reduction in the total fertility rate (\textbf{Figure 20}). The proportion of married women using long-term contraceptive methods increased from 4.7 per cent in 2005 to 15.3 per cent in 2008 and to 33 per cent in 2010. The total extent of modern contraceptive use improved from 10.3 per cent in 2005 to 27.0 per cent in 2008 and to 45 per cent in 2010. This is still well short of the 2012 EDPRS target of 70 per cent. There remains an unmet need for contraception, with 88 per cent of married women saying they did not want any more children, or they wished to delay having their next child, compared with a contraceptive prevalence rate of 45 per cent (Ministry of Health et al., 2011).

\textbf{Figure 9: Married women’s use of modern contraception 2000-2010}

![Married women’s use of modern contraception chart]

Source: DHS, 2000, 2005; IDHS, 2007; DHS, 2010

\(^{16}\) Less than 10 per cent of deaths were recorded in referral hospitals (7.69%) and health centres (6.33%). The three main causes of all deaths were severe bleeding (34%), sepsicaemia (12%) and malaria (8%). The main contributory factors were delays in consulting a health facility, delays in recognising signs of complications, and the use of traditional medicine at the community level. At health centres the main factors were delays in making a correct diagnosis and inadequate supervision of women in labour. At the district level the main factors were too few nurses, delays in making a correct diagnosis and getting test results, inadequate supervision and care, lack of resuscitation equipment in ambulances, blood out of stock and lack of communication between health centres and district hospitals (Ministry of Health, 2011).
The HMIS shows a wide variation of uptake by district. Use of contraception also varies by education and place of residency. According to the 2010 DHS (Ministry of Health et al, 2011), 37.3 per cent of married women with no education used modern contraception compared with 46.3 per cent of those with completed primary education and 52.5 per cent of those with secondary education. Married women in urban areas were more likely to use modern contraception than those living in rural areas - 47 per cent compared with 44.9 per cent. The use of modern contraception was lower in the Western Province at 36 per cent compared with between 46 and 52 per cent in the rest of the country. Young married/cohabiting women are less likely than the average to use modern contraception - 30.6 per cent of 15-19 year olds and 20-24 per cent of 20-24 year olds (Figure 10).

Secondary analysis of 2005 DHS data found that the urban poor, and the rural population regardless of wealth, had the highest fertility, the lowest contraceptive use and the greatest unmet need for FP. In addition, there was a strong correlation between relative wealth and use of private sector contraceptive products and services among urban women. Youth and unmarried women are under-served and require greater attention by Government and FP providers (Pandit-Rajani et al, 2010).

The government has raised concerns about the large number of health centres managed by FBOs and has a policy of providing a secondary post in the vicinity of faith-based health facilities so that contraceptive services are available. However, this requires additional resources (Ministry of Finance and Economic Planning, 2011). In 2007, faith-based leaders agreed with the government that they would not oppose contraceptive provision.

2.5.3 HIV and AIDS
The target of the National Strategic Plan on HIV/AIDS 2009-2012 (Ministry of Health, 2009b) is to halve the incidence of new HIV infections. To do this there is an emphasis on reaching the most at-risk populations with a combination of prevention measures that address their specific needs and re-orientating prevention programmes to ensure continuity of education over time. At-risk groups are sex workers, discordant couples, truck drivers and men who have sex with men. Young people aged 15-24 have also been identified as at-risk with young women significantly more at risk than young men. One strategy to increase young people’s knowledge about HIV and how to protect themselves is through Youth Friendly Centres (see later). Another strategy to reduce HIV transmission is to encourage men to be circumcised.

The Ministry of Health has recently published its Adolescent Sexual Reproductive Health and Rights Policy (2011a) which sets out the basic Youth Friendly Sexual and Reproductive Health Care Package that will be provided by health services. It will include: information on SRH and rights; access to FP; antenatal, delivery and postnatal care; confidential counselling and testing;
prevention and treatment for HIV and other sexually transmitted infections; information and vaccination for cervical cancer; the prevention and management of gender-based violence (GBV); and prenuptial consultations.

Data from the 2005 DHS (National Institute of Statistics et al., 2006) found HIV prevalence of 3 per cent in the general population aged 15-49 years. HIV prevalence in urban areas (7.3%) was much higher than in rural areas (2.2%); and HIV prevalence in women (3.6%) significantly higher than in men (2.3%). An analysis of trends in individual sentinel surveillance sites from 2005 to 2007 shows a very mixed picture, with no obvious pattern of increases or decreases in HIV prevalence according to the geographic location, urban or rural (Rwanda National Strategic Plan on HIV and AIDS 2009-2012, 2009).

There seems to have been only a modest decline in prevalence rates since 2000\(^{17}\). The *HIV, AIDS and STIs 2008 Annual Report* reported global prevalence rates declining from 5.2 per cent in 2002 to 4.1 per cent in 2005 with an increase to 4.3 per cent in 2007. In 2008 the proportion of people who tested positive for HIV following voluntary testing was 3.7 per cent for women and 3 per cent for men. A Behavioural Biological Survey (BBS) conducted in 2010 found that HIV prevalence had increased among young people aged 16 to 19 years in two areas of Kigali (Biryogo and Gikondo) and was 16 per cent compared with a national HIV prevalence rate of 0.5 per cent for young people in the 2005 DHS (National Institute of Statistics et al., 2006). Some of these young people could have been infected with HIV through mother-to-child transmission, as HIV was first identified in Rwanda in 1983. An alternative explanation is that young men are having unprotected sex with sex workers during the summer holiday when they have time on their hands and some money and that young women are having sex with older men (Key informant interview). Young women, who are more likely to be infected than young men, tend to have sex with older men.

Another BBS conducted in 2010 amongst female sex workers found a high HIV prevalence rate of 51 per cent. Condom use amongst female sex workers with both paying clients and regular partners was inconsistent and suggests that the figures of 81.8 per cent in 2000 and 86.8 per cent in 2006 for female sex workers reporting using a condom with their most recent client (quoted in MTR) are unreliable as a guide to behaviour. Anyone having unprotected sex with sex workers is putting themselves at considerable risk of HIV infection.\(^{18}\) Persisting negative attitudes towards women as sex workers and not men as clients, together with the criminalisation of sex work, also continue to undermine HIV prevention efforts. Women and girls often have less power to insist on safer sex, and gender norms continue to promote high rates of partner exchange among men (Ministry of Health, 2009b).

There has been a decline in mother-to-child transmission rate from an estimated 21.5 per cent rate in 2005 to 2.6 per cent in 2010 (*Figure 11*). However, following a dramatic decline between 2005 and 2008 the rate has remained stable.

Knowledge of HIV is high with no variation by background characteristics. Over 90 per cent of men (92%) and women (91%) aged 15-49 years know that using a condom reduces the risk of HIV and 85 per cent of women and 79 per cent of men say that limiting sexual intercourse to one uninfected partner reduces the risk (*Figure 12*).

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17 Reliable up-to-date data on HIV prevalence will not be available until the full findings of the 2010 DHS are published.
Overall, 79 per cent of women and 74 per cent of men know that both methods reduce the risk of infection. Women who live in rural areas, young people aged 15-19, those who are not married and those with little education are less well informed. The least well informed groups are men who are divorced/separated/widowed or have never had sex, and women in the Western Province (Ministry of Health et al, 2011).

Young people aged 15 to 24 years are an especially vulnerable group for HIV risk behaviour, but a relatively high proportion of them have knowledge of HIV prevention methods (Figure 13). Young women are better informed than young men and knowledge about HIV has increased among both female and male youth since 2000 (Figure 14).
Data from the BBS suggest that a much lower proportion of youth have a complete understanding of HIV risks than suggested by the findings from the DHS (Figure 15). The proportion was lower in 2011 than in 2006 and was only 10.2 per cent for those aged 15-24. It was lower among those aged 15-19 years than those aged 20-24 years and among young women than young men.

Although the majority of men and women say that the risk of HIV transmission can be reduced by using a condom every time they have sex, only 29 per cent of women and 28 per cent of men who had had more than one sexual partner in the previous 12 months reported using a condom in their last sexual encounter in 2010 (Ministry of Health et al., 2011). The proportion of women who did so had increased from 2005 when it was 19.7 per cent, but declined for men from 40.9 per cent in 2005. However, the proportions are higher for young people, with 58 per cent of young men and 29 per cent of young women saying they had used a condom in their last sexual encounter. This is an increase compared with 2000 and 2005 for both young women and men (Figures 16 and 17).
Another important aspect of prevention is knowledge of HIV status. The number of people taking a voluntary HIV test has increased significantly (Figure 18), but it is estimated that only 19.6 per cent of the population knew their HIV status in 2008, well short of the 2012 target of 40 per cent (Nyandekwe, 2011).

The National Strategic Plan for Comprehensive Condom Programming in Rwanda 2009-2012 supports the implementation of the 2005 Condom Policy by ensuring condoms are freely available and accessible for the prevention of HIV and sexually transmitted infections (STIs) and/or for contraception. It also aims to address cultural barriers and stigma that discourage condom use and to integrate the HIV/STI prevention service with the FP service.

The 2008 situational analysis of condom programming found that while condom use had generally increased amongst women, and was increasing slowly amongst sex workers, it was declining amongst all men except truck drivers, amongst whom the rate of condom use had remained stable (National Aids Control Commission, 2009). The study carried out to inform the Strategic Plan found evidence of health facilities running out of condoms. Condoms in Rwanda are funded by donors, being provided either directly, or through social marketing by Population Services International (PSI)-Rwanda, and the numbers distributed has increased since 2008 (Figure 19). Research on availability of socially marketed condoms conducted by PSI-Rwanda in 2010 found that there were no problems with availability in Kigali City and availability was good in the other Provinces apart from the Western Province, where the rate was only 57.9 per cent (PSI Research Division Rwanda, 2010).
Much emphasis has been placed on HIV prevention education in schools and the need to use condoms. Preliminary findings from on-going research into school pupils’ knowledge and understanding of HIV transmission suggests that only those who attend HIV Clubs have any real awareness and understanding (Health Development Initiative, forthcoming). However, sexually active young people in school are finding it extremely difficult to access condoms and other SRH services due to negative attitudes of health workers to sexually active unmarried young people and the absence of condoms in schools and places where young people congregate (Key informant). The Minister of Health issued a statement on the 9th November 2011 stating that the government was in favour of sexual and reproductive health education, but not condoms in schools (reported in New Times, 10th November, 2011).

A key issue to emerge from the literature on SRH in Rwanda is the specific needs of adolescents. It is reported that they are less likely to have access to information, commodities (contraceptives and condoms) and health insurance than their elders (Binagwaho, 2009). Adolescents are becoming sexually active earlier, but contraceptive use remains low. The Government of Rwanda began to address this issue with the establishment of Youth Friendly Centres (YFC) in 2005. By the end of 2009, there were 14 YFCs with half of them supported through funds from the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) and three by One UN including UNFPA. These YFCs focused mainly on HIV testing and counselling and not SRH services. By the end of 2010, 12 health facilities offering a Youth Friendly Health Service (YFHS) were operational and the Government is committed to offering a basic package of YFHS at all health facilities (Ministry of Health, Maternal Child Health, 2011a).

2.5.4 Population and Development

Up-to-date high quality statistical data are essential for planning at both central and local levels, as is an understanding of the need to use such data and the capacity to be able to use it. In Rwanda the National Institute of Statistics (NISR), reporting to MINECOFIN, is responsible for the production and quality assurance of statistical data. The last population census was in 2002, with the next one scheduled for 2012. A national Integrated Management Information System (IMIS) is being developed to support evidence-informed policy-making and planning, and a vital registration system is being introduced. A National Strategy for the Development of Statistics (NSDS) 2009-2014 was approved in 2010 to guide NISR activities. A number of regular country-wide surveys are conducted, including Demographic Health Surveys (2000, 2005, 2008, 2010) and the Integrated Household Survey (2000/2, 2005/6, 2010/11). There remains, however, a lack of capacity to use

19 Youth Friendly Centres are the responsibility of the Ministry of Youth and districts and have been supported by the UNFPA Population and Development team. Youth Friendly Health Services are the responsibility of the Ministry of Health and district hospitals with supported provided by the UNFPA Reproductive Health team.
the statistical data for policy and planning purposes in the NISR, in government ministries and at a decentralised level (Abbott and Rwirahira, 2010; RALGA, 2010).

Rwanda continues to face a rapidly growing population with a population growth rate of 2.9 per cent, high fertility rates, and land shortages due to high population density of 407 people per square kilometre. The Government recognises the negative impact of rapid population growth on socio-economic development. A National Family Planning Policy 2005-2010 (Ministry of Health, 2006) was introduced in 2005 and all ministries were required to develop action plans for addressing population issues in their sectors. A revised Draft National Population Policy (Ministry of Finance and Economic Planning, 2010a) was developed in 2010 to:

1. continue progress to lower the Total Fertility Rate (TFR) and slow down population growth;
2. make significant investment for young people in Rwanda;
3. implement strategies to lower child, infant and maternal mortality (Ministry of Finance and Economic Planning, 2010).

The EDPRS 2012 Target for the TFR of 4.5 has almost been achieved, and if the current rate of decline continues the Vision 2020 TFR target of 4 should be achieved by 2012 (Figure 20). However, the figure of 4.5 children per woman is still well above the 2008 figure of 3.3 children as the average family size that women said they thought was ideal and suggests that there is an unmet need for contraception. This is given added weight if we compare the 2010 figure for use of modern contraception (45%) with the 2008 figure of 71 per cent of women intending to use modern contraceptives (Ministry of Health et al., 2009; 2011).

The population structure in Rwanda is young with an average age of 21.2 years, and half the population are younger than 17.4 years old. The rural population is younger (21 years on average) than the urban population (22.2 years on average), and the male population is younger (20.5 years on average) than the female population (21.9 years on average). Given the demographic situation, population size is expected to continue to grow, especially in rural areas and amongst young people and the less well-educated (Ministry of Finance and Economic Planning, 2010a). In 2010, 73 per cent of the population were below the age of 30\textsuperscript{21}; by 2025 this proportion is expected to decrease to 67 per cent, and finally, by 2050, to 58 per cent – still more than half of the population (Ministry of Finance and Economic Planning, 2010:10). Young people aged 15 to 24 years are an important group as this is the period of transition from childhood to adulthood and they are a key group to target in terms of FP and safer sex. In 2011, 20.5 per cent of the population are in this age group, with a predicted marginal decline by 2020 (Figure 21).

\textsuperscript{20} Lead responsibility for managing population growth has passed from the Ministry of Health to the Ministry of Finance and Economic Planning. A draft revised Family Planning Policy is due to be published in January 2012.

\textsuperscript{21} There are different definitions relating to young people. The Rwandan Government defines youth as 18-34 years, the United Nations (including UNFPA) defines young people as 10 to 24 years and youth as 15 to 25 years and the World Health Organization defines adolescents as 10 to 19 years.
Adolescent pregnancy has a negative impact on young women’s education and employment opportunities and young mothers are at greater risk of complications during pregnancy and of dying from pregnancy-related causes. In 2008, six per cent of adolescent girls had begun child bearing, 2.5 per cent of 16-17 year olds, 9 per cent of 18 year olds and 14 per cent of 19 year olds. Adolescent girls account for four per cent of total fertility, but comprise 19 per cent of the population aged 15-49 years. The age specific fertility rate for 15-19 year olds was 40 in 2008 and 41 in 2010. This compares with 211 and 189 respectively for 20-24 year olds with 25 to 29 year olds having the highest age specific fertility rate followed by 30-34 year olds (Figure 22).

There has been a decline in fertility rates for adolescents and young adults, most notably for adolescents (Figure 23).

2.6 Gender equity
Rwanda is hailed as a global example of good practice for representation of women in Parliament with 56.3 per cent women (the highest level in the world). However, at Sector level only 13 per cent of Executive Secretaries were women in 2010 (data provided by MINALOC). In 1996, the National Women’s Council (NWC) was set up to coordinate Women’s Councils across the country.
to provide a framework for information exchange, women’s mobilisation and advocacy. The NWC coordinates the election of women for the reserved seats in Parliament.

A Gender Monitoring Office (GMO) was established in 2008 to develop gender-specific performance indicators and a comprehensive M&E system. Institutional capacity in gender equality is being built, with accountability measures in places. Gender-disaggregated data are required but are not yet available in all sectors. Gender-sensitive budgeting is also being implemented and Gender Budget Statements are being piloted in Agriculture, Education, Health and Infrastructure. The GMO review of progress towards the representation of women in decision-making bodies found that they are under-represented in a majority of institutions - the benchmark is the constitutional requirement for 30 per cent of posts in decision-making bodies to be held by women.\textsuperscript{22} (Table 3). Women tend to be better represented in elected positions where the law stipulates at least 30 per cent representation.

<table>
<thead>
<tr>
<th>Type of Institution</th>
<th>Number</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Power</td>
<td>9</td>
<td>75%\textsuperscript{23}</td>
</tr>
<tr>
<td>High Executive Decision Making Positions</td>
<td>6</td>
<td>23%\textsuperscript{24}</td>
</tr>
<tr>
<td>Executive Technical Decision Making Positions</td>
<td>1</td>
<td>8.3%\textsuperscript{25}</td>
</tr>
<tr>
<td>Legislative Power</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>High Legislative Decision Making Positions</td>
<td>1</td>
<td>12.5%</td>
</tr>
<tr>
<td>Judiciary</td>
<td>6</td>
<td>26%</td>
</tr>
<tr>
<td>Civil Society Decision Making Organs</td>
<td>1\textsuperscript{26}</td>
<td>0%</td>
</tr>
<tr>
<td>Private Sector Decision Making</td>
<td>2</td>
<td>50%\textsuperscript{27}</td>
</tr>
<tr>
<td>High Decision Making in Private Sector</td>
<td>5</td>
<td>0%</td>
</tr>
<tr>
<td>Technical Decision Making Private Sector</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>34</strong></td>
<td><strong>34%</strong></td>
</tr>
</tbody>
</table>

Source: GMO, 2011


The vision of the National Gender Policy (Ministry of Gender and Family Promotion, 2010) is to set “Rwandans society free from all forms of gender-based discrimination and see both men and women participate fully and enjoy equitably from the development process” (2010: 19). The policy calls for mainstreaming gender in all sectors (public and private), policies, programmes and projects. The Ministry of Gender and Family Promotion (MIGEPROF) coordinates the implementation of the policy, which sets out key objectives for the empowerment of women in line with the EDPRS priorities.

\textsuperscript{22} Law No 27/2010 of 19/06/2010 requires that there is at least 30 per cent representation of women in all electoral processes.

\textsuperscript{23} This is based on the number of institutions for which data were available. No information was available for 6 out of 18.

\textsuperscript{24} Based on 26 out of 29 institutions for which data were available.

\textsuperscript{25} Based on 11 out of 12 institutions for which data were available.

\textsuperscript{26} Data are not available for 7 out of 8.

\textsuperscript{27} Data are not available for 2 out of 4.
The National Gender Cluster brings together Government and all stakeholders, including ODPs, the private sector, representatives of NWC and NGOs and CSOs, to discuss and coordinate the implementation of the National Gender Policy. Government Gender Focal Points have been appointed in all Ministries to influence gender-sensitive decision making. They are charged with monitoring the progress towards implementation of the National Gender Policy, ensuring that gender-disaggregated data are collected in all sectors and ensuring that all policies, programmes, projects and budgets are gender-responsive.

The Parliamentary Women’s Forum was created to enable women Parliamentarians to work together to review laws so that they do not discriminate against women and to develop gender-sensitive laws. The Forum was responsible for the Law on Prevention and Punishment of Gender-based Violence No. 59/2008. The 2005 DHS (Ministry of Health et al, 2006) found that 37 per cent of women aged 15-49 years had experienced gender-based violence since the age of 15 years and 19 per cent in the 12 months previous to the survey. In a survey for the Rwanda Men’s Resource Centre (Slegh and Kimonyo, 2010) 57 per cent of women said they had experienced partner violence and 38 per cent of men said they had committed GBV. The authors suggest that the difference between the reported incidence rates for men and women is because men often think they have a right to sexual intercourse with their wife whenever they want it and some men may not consider a slap as violence.

The legislation on GBV is aimed at preventing and punishing GBV, including rape in marriage, and the intentional transmission of disease through sexual intercourse. The law recognises that GBV is a cause for divorce and stipulates penalties for rape, spousal harassment, sexual slavery, sexual harassment and torture, and gender-based human trafficking (Republic of Rwanda Official Gazette, 2009a). Two One Stop Centres for GBV have been established and provide medical and psychosocial care, legal support and HIV prevention. They also sensitise community members on GBV. There are Gender Desks and free hotline services for victims of GBV in the Rwanda National Police, Rwanda Defence Force and in the National Public Prosecution Authority.

Matrimonial Law No 22/99 (Official Gazette, April 1999) gives women the same rights of succession as men, the Organic Land Law No 08/2005 (Official Gazette, June 2005) provides for equal access to land for men and women and the Labour Law No. 13/2009 gives men and women equal rights in employment. The Girls’ Education Policy (Ministry of Education 2008) was approved in 2008 to achieve gender equality in education at all levels. This Policy is being implemented through the Girls’ Education Strategic Plan 2008-2012 at district, school and institutional levels.

Although considerable progress has been made towards achieving gender equality, women and girls continue to be disadvantaged, especially women living in poverty and those in rural areas. Women are employed mainly as dependent family workers and are significantly less likely than men to be in decent paid employment. Women, on average, work 20 hours a week more than men, and have significantly less leisure time (Strode et al., 2007). Maternal mortality rate remains high and the burden on women of multiple births and demanding domestic duties, such as collecting wood and water, is very high. There are insufficient RH staff and health care facilities, especially in rural areas, which impacts negatively on maternal and child health outcomes. Substantial improvements in main roads have increased the movement of goods between major urban areas. However the poor condition of feeder roads and inaccessibility of some rural villages continue to contribute to high levels of maternal and infant mortality in cases of emergency (MIGEPROF,
2010). Well defined gender-sensitive indicators need to be developed as part of a national system to monitor gender differences and advocate improvements where needed.

MIGEPROF recognises the need to include men in any strategic intervention to address gender equality. Alongside this, the need for greater involvement of men in promoting contraceptive use was noted in the 2006 National Family Planning Policy. This is something that has been subsequently promoted through school-based FP education and community mobilisation campaigns. Moreover, gender stereotypes are not challenged among younger people, and young girls and women (18-24 years) report unmet FP needs (Umurungi, 2009).

### 2.7 Progress towards the Millennium Development Goals

<table>
<thead>
<tr>
<th>MDG Goal</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eradicate extreme hunger and poverty</strong></td>
<td>The proportion of the population living below the national poverty line decreased marginally between 2000 and 2006 from 60% to 57%. The findings from the 2010 DHS are awaited, but it seems unlikely that the 2015 target of 23.8% will be met.</td>
</tr>
<tr>
<td><strong>Achieve Universal Primary Education</strong></td>
<td>The education targets are all on track to be met with a 94% net enrolment rate, a gross primary school completion rate of 74.5% and a literacy rate of 76.8% for youth aged 15-24 years.</td>
</tr>
<tr>
<td><strong>Promote Gender Equality and Empower women</strong></td>
<td>The targets for girl’s education and proportion of women in Parliament have already been met.</td>
</tr>
<tr>
<td><strong>Reduce Child Mortality</strong></td>
<td>A reduction in the infant mortality rate against the target looks challenging with the 2010 figure being 50 against a target of 28. The target for under-five mortality looks as if it will be achieved, with the 2010 rate being 76 against a target of 50.</td>
</tr>
<tr>
<td><strong>Improve Maternal Health</strong></td>
<td>The most reliable figure for maternal mortality is the 2005 DHS figure of 750, making it seem unlikely to meet the 2015 target. However, there is evidence that maternal mortality rate is declining rapidly and the 2010 DHS findings will enable a more robust judgement to be made.</td>
</tr>
<tr>
<td><strong>Combat HIV/AIDS, Malaria and other Diseases</strong></td>
<td>Good progress is being made in fighting HIV and all those who need it have access to antiretroviral therapy. The issue is poor uptake, not availability of treatment. Progress has been made in fighting malaria and other diseases with significant declines in mortality and morbidity from malaria. Less progress has been made in reducing mortality from Tuberculosis. Lack of baseline data makes measuring progress problematic.</td>
</tr>
<tr>
<td><strong>Ensure Environmental Sustainability</strong></td>
<td>Lack of data makes measuring specific targets for sustainable development difficult. However, there is significant evidence of environmental degradation although the government is committed to environmental sustainability.</td>
</tr>
</tbody>
</table>

---

28 Non-farm paid employment with a formal contract.
<table>
<thead>
<tr>
<th>MDG Goal</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The proportion of people with access to improved drinking water in 2006 was 59.9% against a 2015 target of 82%. Although data from the 2010 DHS is awaited there are strong indications that significant progress has been made since 2006 and there is a possibility this target will be met.</td>
</tr>
</tbody>
</table>

Source: Abbott and Rwirahira, 2010, 2011

2.8 Summary

Despite the encouraging trends in the national data presented in the figures above, dramatic differences remain, especially the negative relationships between length of education of women and in rural women’s access to services and contraceptive commodities. In 2008 for example, 27 per cent of married women used modern contraception, but this varied from 22 per cent of women in the lowest wealth quintile to 27 per cent for women in the middle and fourth quintile to 39 per cent for women in the highest (richest) quintile.

These inequities emphasise the pressing need for increased attention to further improve women’s access to education and, a focus on the poorest quintile and those living in under-served areas. To reach the “hard to reach” will call for increased resources and more innovative ways of addressing their multiple needs.

The specific sexual and reproductive needs (including HIV) of adolescents for accurate and appropriate information and access to quality Youth Friendly Health Services and commodities is also emerging as a priority for future attention.

This chapter has commented on the overall progress made in governance, population and RH, and gender equality in Rwanda and the following chapters will describe the specific part played by UNFPA in its 6th CP.
3. UNFPA 6th CP: Response Programme Strategies

3.1 UN and UNFPA Response
The United Nations Development Assistance Framework (UNDAF) comes under the umbrella of One UN. Rwanda is one of eight pilot countries for the One UN Initiative which began in 2007. The Initiative is expected to result in more efficient and effective working by strengthening the UN planning and coordination process, tying funding to the Common Operational Document (COD) and channelling funds to the highest priority needs. Under the Initiative, UN funds and programmes in Rwanda are expected to work collaboratively and in partnership with the Government. The purpose of the One UN Fund is to support and coordinate the mobilization, allocation and disbursement of funds to the UNDAF, including the mobilization of funds to support the unfunded portions of the COD. Donors are encouraged to contribute multi-year pooled/unmarked resources, but if this is not possible then they are to earmark funds for one of the five main results of the UNDAF/COD.

3.2 One UN
The Delivering as One (DaO) Programme was adopted by the UN in 2006 and was designed to:
1. ensure the consolidation and coherence of UN activities in line with the principle of country ownership at country, regional and headquarters levels;
2. establish appropriate governance, managerial and funding mechanisms to empower and support consolidation, and link the performance and results of UN organizations to their funding;
3. ensure a focus on outcomes, responsiveness to needs and the delivery of results as measured by advancing the MDGs

The four pillars central to the reform are: One UN Programme; One UN budgetary Framework; One Leader; and one Office.

The Government and the UN entered into a five year partnership agreement in 2008 as outlined in the UNDAF (subsequently extended by six months to coincide with the Rwandan budget cycle) to address the country’s development vision as set out in Vision 2020 (Ministry of Finance and Economic Planning, 2007) and the EDPRS (Ministry of Finance and Economic Planning, 2007). The MINECOFIN provides overall coordination and all ministries and relevant NGOs are partners in the planned activities.

3.2.1 Division of Labour
The other UN agencies working in Rwanda in addition to UNFPA are: the Food and Agricultural Agency (FAO); International Fund for Agricultural Development (IFAD); International Labour Organization (ILO); UN Joint Programme on AIDS (UNAIDS); UN Capital Development Fund (UNCDF); UN Conference on Trade and Development (UNCTAD); UN Development Programme (UNDP); UN Environment Programme (UNEP); UN Educational, Scientific, and Cultural Organization (UNESCO); the UN Agency for Human Settlements (UN-HABITAT); UN High Commissioner for Refugees (UNHCR); UN Children’s Fund (UNICEF); UN Industrial Development Organization (UNIDO; UNWomen; World Food Programme (WFP); and the World Health Organization (WHO).
The UNDAF (operationalized through the COD) aims to ensure that each agency works in areas of its comparative advantage and the UN provides a collective, coherent and integrated response to the needs and priorities of the Government. The operationalization of One UN has led to joint procurement and some joint provision of services. The DaO Evaluation Report indicates that joint planning reduced duplication, enabled better use of expertise and sharing of expertise in gender mainstreaming and M&E. However, it found there was a lack of evidence of substantial cost saving or of a specific plan for reducing transaction costs (Universalia Management Group, 2010).

3.2.2 UN aid effectiveness in Rwanda

The UN provides technical assistance and financial aid to the Government. Technical assistance is provided directly by the UN and technical experts are recruited by Head Office in New York and paid directly by them (Key informant interview). In-country aid is transferred directly to the implementing agency, and while it is reported to the DAD much of it is not ‘on budget’ and therefore not scrutinised by Parliament. The Government’s assessment of the UN in 2008 against the Donor Assessment Framework found that only five out of the 15 targets for which baseline data were available had been met (Ministry of Finance and Economic Planning, 2009) and in 2009/10 only three targets out of the 14 for which a target had been set were met (Ministry of Finance and Economic Planning, 2010). An overview of the UN and UNFPA alignment with the commitments of the Paris Agenda and the Rwandan Aid Policy are shown in Table 5.

Table 4: UN and UNFPA Alignment with Paris Agenda and Aid Policy of the Government of Rwanda

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ownership</td>
<td>Government preference is for general budget support and, failing that, sector-wide support. This gives the Government greater control to spend in line with its policies and strategies. It also permits Parliament, local government, CSOs and citizens to hold government accountable. UNFPA provides project funding to both central and local government and NGO implementing partners, although the bulk goes to government implementing partners (IPs). UNFPA provides financial support directly to the IP. The funds it provides to government agencies could be ‘on budget’, but have not been included in the Finance Bill to date as the necessary information was not provided in a timely manner. UNFPA financial support is reported to the DAD. UNFPA technical support is directly financed by Head Office in New York.</td>
</tr>
<tr>
<td>Alignment[^5]</td>
<td>The UNDAF and the UNFPA 6th CP are aligned with Vision 2020 and the EDPRS and areas were jointly identified by the Government and UN Country Team. UN and UNFPA are involved in EDPRS M&amp;E systems. National systems (usually government ministries) are used to transfer financial aid to the IPs.</td>
</tr>
<tr>
<td>Harmonization</td>
<td>The results areas in the UNDAF are based on the comparative advantage of each UN agency. One UN is intended to harmonize the UN agencies and reduce transaction costs for implementing agencies. Key informants had mixed views as to whether this was the case as they still had to deal with the different agencies. In the future 7th CP UNFPA has agreed to work in only two areas – RH and PD - in line with the Government’s Division of Labour Policy. UN has agreed to harmonize its planning cycle with the Government Budget Cycle and extend the 6th CP to June 2013.</td>
</tr>
<tr>
<td>Predictability &amp; Transparency</td>
<td>The UN has fixed five-year programmes and provides a non-binding indication of future aid flows. Information is provided for DAD.</td>
</tr>
</tbody>
</table>

[^5]: The UN does not give general budget support or sector wide budget support, but it does fund government agencies directly so that funds are spent through government systems.

[^5]: Annex 5 shows the alignment between UNFPA CP and EDPRS targets.
## Criteria | Assessment
--- | ---
Results & Mutual Accountability | The UN participates in the Donor Assessment Framework whereby the Government assesses the performance of donors. UNFPA was one of the agencies to provide information.  
The UN also participates in the Performance Assessment Framework where the ODPs assess the performance of the Government.  
Development partners are involved in the M&E of **EDPRS**.  
UNFPA, through its PD component, provides support to the MINECOFIN to improve the quality of statistical data for M&E.

### 3.2.3 Coordination mechanisms contributing to the achievement of expected results

The **UNDAF 2008 to 2012 Rwanda** (UN Rwanda, 2007) sets out the role of each UN agency. The contribution of UNFPA is defined in the UNDAF and also in the UNFPA Rwanda 6th CP (UNFPA Rwanda, 2010).

The COD is a Joint Programme of all the UN agencies in Rwanda and is funded by a combination of core and non-core resources of the UN organizations and the ‘One UN Fund’. The core resources remain within the control of each agency. The management and accountability arrangements for the COD are intended to ensure a coherent efficient and results-based management system based on the M&E Framework and linked to resource allocation. The Minister of Finance and Economic Planning is the Chair of the One UN Steering Committee and the UN Resident Coordinator is the Secretary. The Steering Committee, which meets every two months, is responsible for ensuring that the One Programme is closely aligned with and operationalizes the UNDAF outcomes, the **EDPRS, Vision 2020** and the MDGs. Other members include representatives of UN Agencies and the donor community. The Steering Committee decides on the strategic orientations for planning documents and monitors progress in implementing the **DaO Programme**. The One UN Fund is administered by the UNDP.

The UN Country Team (UNCT) is responsible for mobilising resources to fill the funding gap in the UNDAF. Resources are normally allocated to the One Fund and their distribution agreed by the UN Resident Coordinator. The UNCT ensures the achievement of results and adherence to the **DaO Programme**. The UNCT is chaired by the Resident Coordinator and reports to the Steering Committee. All UN agencies are represented on the Committee which meets every three weeks. The Resident Coordinator is responsible for coordinating development, and overseeing implementation, monitoring and evaluation of the **DaO Programme**. The UNCT approves the planning documents submitted by the UN Theme Groups and the budgetary allocations as recommended by the Office of the Resident Coordinator. Having the Resident Coordinator as the primary contact for Government and other partners has reduced transaction costs and ensured effective dialogue with partners (United Nations Rwanda, 2010).

There are six UNDAF Theme Groups: i. Governance; ii. Education; iii. Environment; iv. Health, Nutrition and Population; v. HIV; and vi. Sustainable Growth and Social Protection. At least one representative from each UN Agency contributing to a theme is represented on the Group and the Theme Groups meet every month or once a quarter. The UNDAF Theme Groups serve as a coordination mechanism to ensure the development, implementation, quality, coherence and consistency of UNDAF results and reports on programme implementation. UNFPA is co-chair of the HIV Theme Group and the Health and Population Theme Group. They are responsible for reviewing the information provided by UN Agencies, producing a consolidated planning document with budget and progress reports for submission to the UNCT. In accordance with this requirement, UNFPA in Rwanda has prepared both financial and audit reports.
There are four UN Task Forces: i. Disaster Management; ii. Gender; iii. Human Rights; and iv. Planning, Monitoring and Evaluation. They provide targeted operational support for the One Programme. UNFPA is co-chair of the Gender Task Force (UNFPA Rwanda 2010).

In the early stages of the DaO there was a delay to the implementation of UNFPA activities due to the time taken for joint planning and preparation. This resulted in some activities scheduled for 2008 being postponed until 2009. At this time weaknesses were also noted in M&E, including data collection and indicator setting (UNFPA Country Office Annual Report, 2008). The CO recognised the need for additional staff to cope with the increased demands of being a DaO Pilot Programme. As a result, the number of staff increased from one in 2008 to 33 in 2011. A training plan for staff was developed in 2008 and technical support was requested from the UNFPA Regional Office to build capacity in areas identified as needing strengthening - for example, M&E. UNFPA has now provided training for the other UN agencies as well as its own IPs.

Although they were generally positive about One UN, a number of concerns were raised by the implementing partners (IPs) and UNFPA informants we interviewed. IPs raised concerns about the disbursement of funds and the extent to which the UN was DaO. Views on the latter differed, with some IPs thinking it had improved coordination and reduced transaction costs and others being less certain. One IP pointed out that a joint programme requires that all the UN Agencies involved play their part and this did not always happen. The UNFPA staff interviewed were concerned about the amount of time the approach takes and the number of meetings. They suggested that a more efficient and effective strategy be devised.

Despite these constraints, early benefits of the DaO Programme have been recognised, in particular the potential for resource mobilization. It has successfully encouraged joint programming between agencies and facilitates a flexible rapid response on emerging development needs. It also enables external partners, as well as the UN internally, to have a clear overview of the financial situation and planning of the One UN Rwanda. In 2008, UN advocacy efforts resulted in an increase in national government allocation for RH commodities from US$ 200,000 to US$ 500,000. Additional funds were also mobilized through sector budget support and the GFATM (UNFPA Country Office Annual Report, 2008). The One Fund has raised US$ 17,219 million un-earmarked funding and the Netherlands and Swedish Sida have both provided additional funding (United Nations Rwanda, 2010; United Nations Rwanda, 2011).

An early benefit of the DaO initiative was an increased capacity to mobilise the media and create awareness of major RH issues. The launch of the White Ribbon Alliance in Rwanda and the involvement of the First Lady as its Patron is one example (UNFPA, 2008). In 2009, the One Voice strategy (a Joint UN Communications Strategy) was implemented and successfully raised the profile of UN issues in Rwanda during the UN Campaign week. A One UN Documentation Centre provides a hub for information about development at the UN in Kigali (United Nations Rwanda, 2010).

The development of Consolidated Annual Plans by the UN Theme Groups has ensured that the activities of the UN in Rwanda are jointly defined, and close collaboration with the Government ensures they are aligned with national priorities (United Nations Rwanda, 2010). The Gender Task Force has provided guidance to ensure that gender is mainstreamed across the UNDAF thematic areas, and all Consolidated Annual Work Plans and joint interventions are systematically reviewed.
using a checklist jointly developed by the Gender and Human Rights Task Forces. The One Fund has enabled the mobilisation of resources and greater transparency (United Nations Rwanda, 2010).

The Government of Rwanda has recognised that the DaO in Rwanda is working well, stating that:

“The UN in Rwanda has now become more effective, relevant and responsive to national needs and priorities than ever before. There is strong ownership, support and commitment at country level from Government, the UN and Donors for this reform” (Statement by Government of Rwanda at Hanoi Conference June 2010, United Nations Rwanda, 2011:53).

An evaluation of the DaO pilot in Rwanda (Universalia Management Group, 2010) concluded that generally the pilot was working well. The overall score on a four point scale (1 = Poor, 2 = Moderate, 3 = Good and 4 = Excellent) was ‘good’, with One Voice and Relevance both scoring excellent. The main recommendations for improvement were to: strengthen and systematise the Performance Measurement Framework; improve harmonisation and development with development partners, CSOs and the private sector; develop better mechanisms to review capacity building and exit strategies; define the niche where it has comparative advantage in the division of labour; develop a common framework for quarterly reporting and sharing of results with development partners and the Government; promote financial transparency and accountability by participating in the Development Partners Assessment Framework and the Common Performance Assessment Framework; and empower the UN Resident Coordinator by giving greater authority to improve services, functionality and response times.

The main challenge identified was the ability of the UN as a whole and the individual UN agencies to synchronize with the Government Aid Policy. The multiple methods of budgeting used by the UN confound transparency and predictability of funding.

3.3 UNFPA 6th Country Programme

The UNFPA 6th CP covers the period 2008 to June 2013 with a budget of US$ 30 million of which US$ 10 million is from regular resources and US$ 20 million is through co-financing modalities. The Paris Declaration on Aid Effectiveness provides the methodological approach adopted, with the Government managing the assistance. The 6th CP is designed to support the Government of Rwanda in the realisation of its vision of becoming a middle-income country by 2020. The programme is derived from the UNDAF to respond to the national priorities as laid out in Vision 2020 and the EDPRS. The thematic priorities and indicators included in both Vision 2020 and EDPRS are consistent with the MDGs.

The overall aim of the UNFPA 6th CP is to contribute to the improvement of the social and economic situation of people in Rwanda and to reduce their vulnerability to shocks. It proposed to do this by contributing to four of the five UNDAF results, namely:

5. good governance is enhanced and sustained;
6. the growth of the population is reduced, with marked improvement in maternal and child health, and the impact of HIV and other major epidemics is reduced;
7. all children in Rwanda acquire a quality basic education and skills for a knowledge-based economy;
8. all people in Rwanda benefit from economic growth, including productive employment, and are less vulnerable to social and economic shocks (sustainable growth and social protection).
The UNFPA 6th CP was developed into three components: i. RH, HIV and AIDS (including education for sexual and RH and HIV); ii PD; and iii. Gender equality.

The COD operationalizes the UNDAF and defines activities for the five year period and the operational modalities governing the relationship between the Government of Rwanda and the UN. The COD links activities that will contribute to the achievement of outputs and results as detailed in the UNDAF and identifies those that UNFPA is responsible for. Each year UNFPA develops Work Plans in collaboration with IPs using a bottom up approach in line with its priorities. UNFPA also monitors and reports on progress towards the achievement of outcomes. These can be linked to EDPRS and the MDGs (Table 5).

The **Reproductive Health (RH) component** contributes to three UNDAF Results: i. reduced child and maternal morbidity and mortality (MDG 4 and 5), reduced incidence of HIV and impact of HIV/AIDS and other major epidemics (MDG 6); ii. growth of the population is slowed down; and iii. the Rwandan population benefits from food security and economic growth, including productive employment and is less vulnerable to natural, social and economic shocks (MDG 1). This component contributes to two of the three EDPRS Results: i. managing the population growth rate and enhancing population development (improved health and nutrition status, enhanced FP, strengthened health financing and pro-poor approaches); and ii. enhanced gains through good governance. It also contributes to the cross-cutting issues of gender, youth and social inclusion.

The **Population and Development (PD) component** contributes to two UNDAF Results: i. good governance enhanced and sustained; and ii. all children in Rwanda acquire a good basic education, knowledge and skills for knowledge based economy and enriched cultural society (MDG 2 and 3). This component contributes to two EDPRS Results: i. managing the population growth rate and enhancing population development (enhanced population skills); and ii. enhanced gains through good governance (enhanced citizen participation in decision making, enhanced local government capacity and improved public accountability) as well as the cross-cutting issue of gender and youth.

The **Gender component** contributes to two UNDAF results: i. good governance enhanced and sustained; and ii. sustainable growth and social protection. This component contributes specifically to MDG 3 and to the EDPRS Result of enhanced gains through good governance, and to gender as a cross-cutting issue in EDPRS.

The MINECOFIN is the overall coordinator of the programme and the implementing partner for the PD component which has two other implementing partners: the Network of Parliamentarians for PD and the Ministry of Youth (MIJESPOC). MINISANTE is responsible for coordinating the RH component including the district hospitals. The gender component works with the MIGEPROF, the GMO and the Rwanda Women’s Parliamentary Forum. Following the MTR the Rwanda Association of Local Government Authorities (RALGA) became the implementing partner for the RH, PD and Gender elements of the programme delivered by the districts. Within each component funding is transferred to the executing organization and technical assistance is also provided (personnel and equipment).
<table>
<thead>
<tr>
<th>Output¹</th>
<th>Outcome¹</th>
<th>Result¹</th>
<th>EDPRS Results and Policy Matrix²</th>
<th>MDG³</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mechanisms for participation and representation for children, young people, women, PLHIV, disabled and historically marginalised people in decision-making including elections at national and decentralised level strengthened</td>
<td>Decentralisation and participation. An effective decentralised administration with emphasis on democratic participation and representation</td>
<td>R 1: Good governance and cross cutting issue of gender, youth and social inclusion</td>
<td>MDG 3 Indirectly all</td>
<td></td>
</tr>
<tr>
<td>National and decentralised level capacities (public and civil society) in gender-sensitive planning, budgeting and financial management strengthened</td>
<td>Evidence-based policy making and accountability: effective policy and socio-economic planning and accountable transparent management of public resources enhanced</td>
<td>Enhanced gains through good governance and cross cutting issue of gender, youth and social inclusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National capacities to generate, manage, analyse and disseminate gender disaggregated data for decision making at all levels strengthened</td>
<td>The use of high quality, disaggregated data will guide policy and socio-economic planning.</td>
<td>Enhanced citizen participation in decision making</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Participatory Planning, M&amp;E system to track progress disaggregated by sex towards MDG and EDPRS targets strengthened</td>
<td>Gender equality. The gender equality dimension is effectively mainstreamed in national development plans and corresponding strategies for the elimination of gender-based discrimination and disparities</td>
<td>Enhanced local government capacity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information systems, including for population data, are fully developed and operational in the public sector</td>
<td>All public and private institutions apply gender-equality principles and standards in their performance, practices and behaviour</td>
<td>Improved public accountability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidenced-informed policy framework for ensuring gender equality and combating other forms of discrimination against marginalised groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capacities and mechanisms of public institutions and civil society to advocate for, coordinate, monitor and evaluate policies and actions related to gender equality strengthened at central and decentralised levels</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The institutional capacity of key development actors is strengthened in areas of coordination, gender-based analysis, planning, policy formation, monitoring and evaluation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National policies, strategies and standards for health and nutrition developed based on research and evidence and with a focus on equity and financing</td>
<td>Effective health system. Equity, effectiveness and efficiency of the national health system improved</td>
<td>R 2: Mortality due to child and maternal morbidity, the incidence and impact of</td>
<td>MDGs 1, 4, 5 and 6</td>
<td></td>
</tr>
<tr>
<td>Increased capacity of the social and health systems to provide a complete, integrated health-care package, including maternal, child, adolescent and youth health services appropriate to different levels and targets</td>
<td>Improved quality, effectiveness and efficiency of the health system, including nutrition, RH, maternal and child health and FP</td>
<td>Managing population growth rate and enhancing population development</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹ Output refers to the specific actions or outcomes that the intervention aims to achieve.
² Outcome refers to the results anticipated from those outputs.
³ Result refers to the ultimate impacts or benefits desired from the outcomes.
⁴ EDPRS Results and Policy Matrix refers to the alignment of the outcomes and results with the MDGs and other relevant policy frameworks.
⁵ MDG refers to the Millennium Development Goals.
<table>
<thead>
<tr>
<th>Output</th>
<th>Outcome</th>
<th>Result</th>
<th>EDPRS Results and Policy Matrix</th>
<th>MDG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity of health services and CSOs to promote and provide a complete and integrated package of health and nutrition services appropriate to different target groups and levels strengthened</td>
<td>Health practice. Adoption of healthy practices and improved access to and quality health services</td>
<td>HIV and AIDS and other major epidemics reduced and the growth of the population slowed down</td>
<td>Enhanced FP</td>
<td></td>
</tr>
<tr>
<td>Strengthened capacity for community organization of community organizations, faith-based organizations and traditional leaders</td>
<td>Coordination, planning M&amp;E and partnership in line with the Three Ones principles, leadership and oversight for an expanded HIV response by national and local coordinating institutions strengthened and sustained</td>
<td></td>
<td>Strengthened health financing and pro-poor approaches</td>
<td></td>
</tr>
<tr>
<td>Capacity at national level and decentralised levels for rapid response to epidemics and other health and nutrition emergencies strengthened.</td>
<td>Prevention of HIV. Protective behaviours adopted and effective prevention services utilised by HIV-exposed population, especially the youth and women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National capacities to develop, review national policies plans and strategies based on evidence (research/M&amp;E) strengthened</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National and regional coordination of and partnership on HIV with public institutions, civil society, private sector and donors strengthened</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased capacity of national and civil society institutions to provide participatory, youth-friendly, HIV prevention services, including life skills and peer education for in- and out-of-school youth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased access to comprehensive package of prevention services (information, education and communication, post-exposure prophylaxis; SRH; sexually transmitted infection management; and voluntary counselling and testing) that focuses on most at-risk groups and the drivers of the epidemic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased access to male and female condoms and new HIV prevention technologies and approaches</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National capacities (public, private, civil society) to stimulate individual and social change and provide a comprehensive package of preventive interventions including new preventive technologies with a focus on the most at-risk populations and youth increased</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Output¹</td>
<td>Outcome¹</td>
<td>Result¹</td>
<td>EDPRS Results and Policy Matrix²</td>
<td>MDG²</td>
</tr>
<tr>
<td>---------</td>
<td>----------</td>
<td>---------</td>
<td>----------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Curriculum reviewed and strengthened to include life-skills and outcome based competencies, including a focus on literacy and culture</td>
<td>Key learning outcomes for children including life-skills and competencies for lifelong learning achieved learning</td>
<td>R 3: All children in Rwanda acquire a quality basic education, knowledge and skills for a knowledge-based economy and enriched cultural society</td>
<td>Managing population growth rate and enhancing population development</td>
<td>MDGs 2 and 3</td>
</tr>
<tr>
<td>Pre- and in-service teacher training systems strengthened to promote effective learning, child centred teaching methodology and a culture of reading</td>
<td>Effective system. The education system is effectively planning, analysing and coordinating the education sector to deliver quality education for all children</td>
<td>Enhanced population skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The institutional capacity for school planning and costing at the district level is strengthened using tools that analyse population dynamics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidenced-based gender and equity focused national policies, planned and strategies strengthened</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National capacities for disaster management (disaster risk reduction, early warning system) mitigation and response strengthened</td>
<td>Disaster management. Effective disaster management system in place to minimise risks and respond to shocks</td>
<td>R5: Rwandan population benefits from food security and economic growth, including productive employment, and is less vulnerable to natural, social and economic shocks</td>
<td>Managing population growth rate and enhancing population development</td>
<td>MDG 1</td>
</tr>
</tbody>
</table>

Sources: ¹Common operational Document for the UN in Rwanda, Final Version 13; Ministry of Finance and Economic Planning, 2007
3.4 UNFPA response through the 6th Country Programme

In evaluating the UNFPA 6th CP the first question is whether the CP is relevant to the development needs of Rwanda. Is the programme in line with the policies and priorities of UNFPA globally and the UNDAF for Rwanda? Is it in line Government of Rwanda’s development goals as set out in key documents, Vision 2020 and the EDPRS?

3.4.1 UNFPA previous assistance to Rwanda

UNFPA assistance to Rwanda began in 1975. The 5th CP ran from 2002-2006 and its goal was to assist the government in improving the well-being and quality of life of the Rwandan population by improving RH, by reinforcing planning for sustainable development and by strengthening gender equity and equality. It executed this through three components:

1. RH - improve RH and eradicate sexual and GBV;
2. PD - improve the national demographic database and its capacity to be utilized for national development
3. Gender – increase community and household participation in development planning and decentralization and increase awareness of gender issues and promote gender equality (Akoto et al 2007).

The 5th CP evaluation found that UNFPA had formed strong partnerships with the implementing agencies and that the level of achievement overall was satisfactory, but disappointing for Population and Development. Cost effectiveness was satisfactory. High staff turnover, shortages of personnel and the lack of capacity at both UNFPA’s Country Office and in the implementing partners proved a constraint to implementation. Specific attention was drawn to the poor performance of the HIMS, the lack of utilisation of demographic data for policy development and planning and the difficulties of coordination at the decentralised level. The planned programme budget was US$ 7 million and US$ 11 million was mobilized, but this was considered to be insufficient. The specific recommendations made by the evaluators of the 5th CP together with action/response by UNFPA CO are shown in Table 6.

<table>
<thead>
<tr>
<th>Recommendation 5th CP</th>
<th>Action Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Areas covered by 5th CP should continue to be supported in 6th CP Framework – RH especially FP in the context of ICPD</td>
<td>RH, PD and Gender are the three areas covered in the 6th CP</td>
</tr>
<tr>
<td>Extend programme beyond 7 Districts</td>
<td>The 6th CP initially worked in 21 districts but this proved unrealistic and the number was reduced to 5 following recommendations of MTR of the 6th CP in 2010.</td>
</tr>
<tr>
<td>Support Government in mobilising additional resources</td>
<td>The indicative budget for the 6th CP was nearly three times that mobilised for the 5th CP. UNFPA mobilises funds through the UN Resident Coordinator. US$ 8.2 million has been raised by the One Fund since 2008.</td>
</tr>
<tr>
<td>Population Units in Provinces and Districts</td>
<td>UNFPA has supported the Government to establish the post of District Statistician with responsibility for population data. More recently districts have appointed some-one to be responsible for Civil Registration. UNFPA have also appointed a Programme Coordinator for each of the 5 districts to support the programme implementation at district level.</td>
</tr>
<tr>
<td>Improve HIMS</td>
<td>A Joint Programme (UNFPA, UNICEF, WHO) is supporting MINISANTE and a new HIMS was recently introduced but much more needs to be done.</td>
</tr>
<tr>
<td>Scale up income generating – training young people etc.</td>
<td>This activity has been continued through the YFC supported by UNFPA, but much more needs to be done.</td>
</tr>
<tr>
<td>Audit of strength of each UN agency</td>
<td>Undertaken as part of establishment of delivering as One</td>
</tr>
<tr>
<td>Improve M&amp;E – Baseline data etc.</td>
<td>Baseline indicators were established wherever possible</td>
</tr>
</tbody>
</table>
### 3.4.2 Current UNFPA Programme

The 6th CP builds on the 5th CP including the strong national and local partnerships that had been formed and is aligned with national priorities, the MDGs as well as the *International Conference on Population and Development Programme of Action*, the *Maputo Declaration on Continental Policy Framework on Sexual and Reproductive Health and Rights* and the *UNFPA Global Strategic Plan*. The *UNFPA Global Strategic Plan* stresses the importance of supporting South-South links, but we found little evidence of this in the 6th CP.

Each component has an UNFPA unit that is responsible for it. There is also a M & E Unit and an Operations Department. See *Appendix 1* for a breakdown of the outcomes and outputs under each thematic area.

UNFPA withdrew from supporting curriculum development due to lack of progress and has not allocated any resources since 2008. UNICEF will assume responsibility for this work in future given their comparative advantage in education.

#### 3.4.3 The Mid Term Review

The programme delivered at the time of the End Line Evaluation had been modified following a MTR (the final report of which was submitted in October 2010). It made a number of specific recommendations to improve the programme (*Table 7*) and the M&E framework (see *Chapter 6*).

### Table 7: MTR Recommendations and UNFPA Actions

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Action</th>
</tr>
</thead>
</table>
| **Capacity enhancement & infrastructure development**  
Enhance institutional and technical capacities to respond to challenges of maternal and child health, SRH, HIV/AIDS, data management and utilization | The CBD has started, but needs to be further strengthened and scaled up. It is anticipated this will be undertaken in the 7th CP. |
| **Combating HIV/AIDS**  
Implement comprehensive condom programme strategy  
Improve availability of condoms at community level  
Strengthen HIV workplace programme  
Reinforce HIV prevention services at health centres | A comprehensive condom programme is being implemented; availability of condoms has increased and RH and HIV services are being integrated at district level. |
| **RH and population growth**  
Conduct national survey on socio-cultural aspects of RHS availability and access  
Use findings to develop strategies to overcome barriers | Reference to a survey in 2011 work plan |
| **Support for key stakeholders**  
GMO collect and publish statistics every 1 or 2 months on institutional compliance with gender equality and quotas | UNFPA has strengthened the GMO as an IP  
The recommendation of publishing data on a bi-monthly basis is unrealistic |
The findings of the MTR backed up by further data analysis suggested a number of major programme changes to reduce fragmentation and increase focus, efficiency and effectiveness. These included reducing the number of districts in which UNFPA worked and the number of implementing partners with whom it worked at a decentralised level. It recommended that MINISANTE be the IP at central level and that support be strengthened to CNLS, GMO, MIGEPROF, MIJESPOC MINECOFIN and RPRPD.

The Government of Rwanda31 agreed that UNFPA would continue to work with the lead IPs and support the NISR in data collection activities, civil registration and the Census. UNFPA continue to focus on technical support for policy dialogue, advocacy and capacity building with IPs. Gender activities at the decentralised level have been taken over by RALGA as the IP for activities at district level. At the decentralised level it was agreed that UNFPA would reduce the number of districts with which it worked from 21 districts in three Provinces to five districts in one province and that MINISANTE would become the lead IP at district level for the District Hospitals and RALGA for activities in the districts relating to all three components. This was to reduce fragmentation and enable UNFPA to support an integrated service delivery package for health facilities and community health care (Table 8). The five districts (Karongi, Ngororero, Nyamasheke, Rubavu and Rusizi) border on the Democratic Republic of the Congo and were selected based on need, historic presence, likelihood of achieving long-term results and opportunities for synergies with other UN agencies.

Table 8: Integrated package delivered at health facility and community levels

<table>
<thead>
<tr>
<th>Health Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Emergency obstetric and neo-natal care (EMONC): capacity building (training, medical equipment, ambulances, tools), maternal and neonatal death audits, prevention and treatment of fistula;</td>
</tr>
<tr>
<td>- Family Planning: capacity building (training and tools);</td>
</tr>
<tr>
<td>- Youth: Youth Friendly Health Services delivery (training of service providers, tools);</td>
</tr>
<tr>
<td>- HIV prevention: VCT, PMTCT, RH/HIV integration;</td>
</tr>
<tr>
<td>- Gender-based violence (GBV): capacity building (training, equipment and commodity, tools)</td>
</tr>
</tbody>
</table>
**Community Level**

- Emergency obstetric and neo-natal care (EMONC): autopsy verbal (capacity building, tools, data collection)
- Family Planning: Community based distribution (CBD), post-secondary (training and tools, equipment)
- Youth: Capacity building of youth networks, association and cooperatives (training, sensitization, tools)
- HIV prevention: promotion of condom availability and use (capacity building of youth network/cooperative/CHWs, sex workers)
- CHWs/FBOs/sex workers: capacity building/service delivery in adolescent sexual and RH (ASRH)/RH/FP/HIV/gender
- Gender-based violence: capacity building of school gender clubs (this activity to be implemented through administrative districts)

UNFPA has undertaken a needs analysis in the five districts through an examination of the District Plans and has identified activities related to UNFPA’s mandate. Based on this, UNFPA supported the districts to develop their annual work plans (AWP), identify baseline indicators for RH and gender and assisted with the collection of baseline indicators where they do not exist. UNFPA has also sensitised local religious leaders in FP in the five districts. An exit strategy was devised for withdrawing from the other 16 districts, with 2011 being a transition year. UNFPA continue to support the YFC in Gicumbi and the One Stop Centres in Kigali and in Gihundwe Hospital in Rusizi District.

### 3.4.4 UNFPA Involvement in Joint Interventions

UNFPA has been involved in joint interventions with other UN agencies under the themes of governance and gender:

- The GBV intervention involves collaboration between UN Women and UNICEF and covers the activities of the UN participating agencies in GBV. It has reduced duplication, although joint interventions are challenging.
- UNFPA collaborates with UNWomen in the Agaseke Promotion Project with Kigali City Council.
- UNFPA collaborates with UNWomen in supporting the National Gender Machinery.
- The joint youth intervention was developed in 2009 and enabled UNFPA to increase funding and to support four Youth Friendly Centres (YFCs) to provide a comprehensive package with additional staffing and equipment (including computers, projectors, DVD players and digital cameras). Pressure of work on UN agencies has made coordination challenging and joint-events are time consuming to organize. UN bureaucratic procedures have led to delays in the recruitment of staff for the MIJESPOC.
- A programme to strengthen Rwanda’s National Evidenced-based Policy Analysis and M&E was agreed in 2011. UNDP, UNFPA and UNICEF supported the establishment of a Monitoring and Evaluation Unit at the MINECOFIN to build government capacity in M&E at national and sub-national levels. One of the key outputs from the project will be EDPRS 2.

The UNFPA Programme components and partners are shown in Table 9.
### Table 9: Programme Components

<table>
<thead>
<tr>
<th>Programme</th>
<th>Project Number</th>
<th>Programme component</th>
<th>Project Description</th>
<th>Implementing Agency</th>
<th>Other Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reproductive health</td>
<td>RWA6R14A</td>
<td>RHR</td>
<td>Policies and standards on RH &amp; rights</td>
<td>MINISANTE (MCH, District Hospitals)</td>
<td>MINALOC, RALGA, RCLS, FBOs, CBOs</td>
</tr>
<tr>
<td></td>
<td>RWA6R24B</td>
<td>RHR</td>
<td>Access to RH Services</td>
<td>MINISANTE (MCH, District Hospitals)</td>
<td>MINALOC, RALGA, RCLS, FBOs, CBOs</td>
</tr>
<tr>
<td></td>
<td>RWA6R31A</td>
<td>RHR</td>
<td>Social change and BCC on HIV Prevention</td>
<td>CNLS</td>
<td>RALGA, ICM, Plus, FBOS, NGOs, RCLS</td>
</tr>
<tr>
<td></td>
<td>RWA6R42A</td>
<td>RHR</td>
<td>Quality HIV Prevention Service</td>
<td>CNLS</td>
<td>RALGA, ICM, Plus, FBOS, NGOs, RCLS</td>
</tr>
<tr>
<td></td>
<td>RWA6R42B</td>
<td>RHR</td>
<td>UN HIV/AIDS Coordination</td>
<td>CNLS</td>
<td>RALGA, ICM, Plus, FBOS, NGOs, RCLS, FBOs</td>
</tr>
<tr>
<td></td>
<td>RWA6R54C</td>
<td>RHR</td>
<td>Improved access to adolescent SRH</td>
<td>MINEFPOC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RWA6R54C</td>
<td>RHR</td>
<td>Improved access to adolescent SRH</td>
<td>ARBEF</td>
<td></td>
</tr>
<tr>
<td>Population &amp; Development</td>
<td>RWA6P15A</td>
<td>Population and development</td>
<td>Population Data Collection</td>
<td>MINECOFIN</td>
<td>NISR</td>
</tr>
<tr>
<td></td>
<td>RWA6P27A</td>
<td>Population and development</td>
<td>Population Family Life Education in schools</td>
<td>MINECOFIN</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RWA6P36B</td>
<td>RH, Gender, population and development</td>
<td>Civil registration and vital statistics</td>
<td>RALGA</td>
<td>MINILORD, MOL, MINECOFIN, RCLS, FBOS, CBOs, NGOs, NISR</td>
</tr>
<tr>
<td>Gender</td>
<td>RWA6G38A</td>
<td>Gender</td>
<td>Gender equality and women's empowerment</td>
<td>MIGEPROF, FFRP, GMO</td>
<td>NWC, KCC, RNP, NGOs, CSOs, FBOS</td>
</tr>
</tbody>
</table>

### 3.4.5 The Financial Structure of the Programme

It is important to understand the funding of the 6th CP. How much is being spent and on what? We need to understand not just what the programme is funding or what the programme outputs are, but whether the programme is delivering good value for the money expended.

The funding for the UNFPA 6th CP comes from three sources:

- UN Headquarters core or regular funds for the programme;
- UN Headquarters vertical funds allocated on the basis of project proposals submitted by UNFPA;
- the One UN fund mobilised by the UN Resident Coordinator and administered by UNDP which generally funds joint projects.

Table 10 shows the budget needed to fund the programme as determined at the outset. Regular sources were mobilised at the outset, but other funds need to be mobilised from other sources, namely the One Fund and vertical funding from UNFPA Head Office in New York.

### Table 10: Financing by Core Programme Area (in million $)

<table>
<thead>
<tr>
<th>Programme Area</th>
<th>Regular Sources</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>RH</td>
<td>6</td>
<td>12.5</td>
<td>18.5</td>
</tr>
<tr>
<td>Population and Development</td>
<td>2</td>
<td>3.9</td>
<td>5.9</td>
</tr>
<tr>
<td>Gender</td>
<td>1</td>
<td>3.6</td>
<td>4.6</td>
</tr>
<tr>
<td>Programme Coordination and Assistance</td>
<td>1</td>
<td>1</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
<td><strong>20.0</strong></td>
<td><strong>30.0</strong></td>
</tr>
</tbody>
</table>

32 Following the MTR, RALGA was selected as the IP for all activities at District level for all components.
Table 11 details the resources mobilized between 2008 and 2010. It is taken from the MTR and is not strictly comparable with the budget provided by the CO Office to the Evaluation Team in October 2011. It provides an indication of the sources of funding for the 6th CP. It shows that by the end of 2010, US$ 17.77 million had been mobilized of the US$ 30 million that 6th CP was costed at, that is 59 per cent. This means the CP is on track to mobilize the necessary resources.

<table>
<thead>
<tr>
<th>Year</th>
<th>Core funds</th>
<th>Vertical funds</th>
<th>One fund</th>
<th>Total Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>2,929,749</td>
<td>2,024,142</td>
<td>1,148,690</td>
<td>6,123,337</td>
</tr>
<tr>
<td>2009</td>
<td>2,936,631</td>
<td>1,750,567</td>
<td>854,654</td>
<td>6,541,641</td>
</tr>
<tr>
<td>2010</td>
<td>3,150,000</td>
<td>1,437,566</td>
<td>1,714,239</td>
<td>5,104,048</td>
</tr>
<tr>
<td>Total</td>
<td>9,016,380</td>
<td>5,212,275</td>
<td>3,717,583</td>
<td>17,769,099</td>
</tr>
</tbody>
</table>

Source: UNFPA, MTR, 2010:39

Figure 24 provides the budget for the period 2008-10 against expenditure. The budget has increased each year with the most noticeable increase being between 2009 and 2010. The 2010 budget was 137 per cent of the 2009 budget, but the amount expended compared with expenditure in 2009 was 109 per cent, indicating poor budget implementation. As Figure 24 shows, total budget implementation in 2010 stood at 74 per cent compared with 96 per cent in 2009 and 93 per cent in 2008.

Figures 25 and 26 show the total budget available by programme and the total amount disbursed. They show that RH has the largest share of the budget and youth the smallest. However, the increase in budget available has been larger for the other components, nearly doubling for PD and Gender.
The extent of under-spent funds raises significant concerns and seems to be recent. As the MTR points out, the amounts under-spent in 2008 and 2009 were relatively small compared with the total budget allocated. However, the under spend in 2010 in all areas except RH suggests that the CO need to take action to ensure higher levels of disbursement in future years. A partial explanation for the under spend could be the re-orientation of the programme following the MTR, but this seems unlikely to account for the under spend on HIV/AIDS, Gender and Youth, as the changes have little impact on these components.

Figure 26: Budget by programme, 2008-2010 ($US)

Our fieldwork findings confirm those of the MTR that there is a significant need for additional resources to develop capacity and for equipment. The IPs we interviewed (including the districts and staff of the District Hospitals) point to the need to build capacity and for additional equipment. Additional resources could be absorbed by some IPs.

However, as Figure 27 shows, the extra budget available has not been translated into an equivalent increase in budget disbursed. In 2010 the HIV component expended 67 per cent of the amount disbursed in 2008, despite the available budget being 120 per cent of the 2008 one. In 2010 the Gender component expended 70 per cent of the available budget, PD 67 per cent and Youth 79 per cent. RH by comparison disbursed 93 per cent of available budget. The total underspend on the budget to date is US$ 1,598,574, 14 per cent of the total budget allocated.

Figure 25: Budget disbursed by component, 2008-2010 ($US)
Figure 28 shows the allocation of the budget to sub-components and proportion of the total budget disbursed by sub-component. Reproductive health has the largest budget at just over a third and youth the smallest at just under 10 per cent. However, budget allocation to components should not be confounded with who benefits. Gender is mainstreamed across the programme and women are the main beneficiaries of spending on RH. There is a focus on youth in the AIDS component which also has a project to support former female sex workers.

Figure 26: Percentage of total budget allocated to components and percentage of total budget expended by components

UNFPA remains dependent each year on raising additional funds from the One Fund and/or Vertical Funding from Head Office. The 2011 Work Plan includes activities for which a significant proportion of funding was not available at the time the plans were prepared. This shows the fragility of the funding and the potential that UNFPA may fail to raise the funds for its budget (DaO Annual Report, 2010). The government have identified the largest funding gap in health as being in maternal and child health, including FP and RH.
4. Findings: Focus Area Analysis

4.1 Introduction
In this chapter we consider the extent to which UNFPA has achieved programme outputs and outcomes. We recognise that the 6th CP still has over a year to run and take this into account. For each outcome and output there is at least one indicator against which UNFPA measures progress. Generally we are able to measure progress to the end of 2010 and in some cases we have been able carry out a trend analysis.

The findings in this Chapter should be seen in the context of Chapters 2 and 3. In Chapter 2 we provided an analysis of the country context focusing on developments in RH, PD and gender. The UNFPA 6th CP contributes to these three areas.

The 6th CP activities include UNFPA technical support to advocacy, awareness raising, behavioural change, capacity building and training, policy dialogue and sensitisation. UNFPA also provides human and material resources, at central and decentralised levels to IPs as well as providing RH commodities and condoms for the prevention HIV and pregnancy. There is a strong emphasis on gender and youth in all three components and strong links between the Gender component and RH. There is a need in all components to collect and use quality data to inform policy development and implementation. UNFPA is also working to support the delivery of an integrated RH service combining FP and safer sex services.

The information used for this analysis is mainly documents provided by the CO\(^33\). These include the Annual Work Plans (AWPs) for 2009 and 2010, UNFPA 2008 Country Office Report and the United Nations Rwanda Delivering as One Reports, 2009 and 2010. A complete list of all documents used is provided in the references at the end of this report.

4.2 Reproductive Health
The RH component is divided into two sub-components, RH and HIV/AID both of which are delivered at national and decentralised levels.

4.2.1 Relevance

Assess the extent to which the 6th CP for productive health has contributed to the defined results of the UNDAF 2008-2012 and to national priorities as set out in the Economic Development and Poverty Reduction Strategy (EDPRS) 2008-2012 and the MDGs, are still relevant and have contributed to solving the problems and meeting the needs of beneficiaries.

The 6th CP is fully in line with the UNDAF and the EDPRS 2008-12 and contributes to the MDGs especially MDGs 4 and 6. The component is in line with the Government’s policies and strategic plans, including the 2009 Health Sector Strategic Plan 2009-12, the Rwanda National Strategic Plan for HIV and AIDS, the National Family Planning Policy and its Five-year Strategy 2006-210\(^34\) and the Reproductive Health Commodity Security (RHCS) Strategic Plan.

\(^33\) All references to outputs in this and subsequent Chapters are based on materials provided in the UNFPA data file unless indicated otherwise. All the materials in the data file are listed in the references.

\(^34\) This Policy is due to be revised to take account of the findings of the 2010 DHS available in 2012.
We demonstrated earlier (Chapter 2.5.2) that there have been significant recent improvements in reducing the maternal mortality rate and increases in the percentage of women giving birth in health facilities, using modern contraception and attending antenatal care. However, there is still room for considerable improvement in each area, with some way to go if the MDGs, EDPRS, Vision 2020 and the WHO targets are to be achieved. We have also showed in Chapter 2.5.3 that HIV/AIDS is a significant issue for the country with a prevalence rate of three per cent, with little evidence of decline in recent years and tentative evidence of an increase of HIV amongst young people. The HIV prevalence rate is also much higher in most at-risk groups, especially female sex workers. The data from the DHS and BBSs indicate that there is a high level of awareness of HIV, but a low level of protective behaviour amongst at-risk groups.

4.2.2 Effectiveness to date

Assess the extent to which the planned outcomes in RH have been achieved by the 6th CP up to 2011 and provide a trend analysis to June 2013

Effectiveness considers the extent to which a programme activity achieves its objectives and the factors that influenced this. A number of projects have been supported by this component at central and decentralised levels, including an emphasis on safe motherhood, with maternal death audits, obstetric fistula care and emergency obstetric and neonatal response being supported. Another important area of support is for outreach FP services, including the training of CHWs and the provision of secondary posts near Catholic-run health facilities.35

UNFPA aims to provide a focused contribution to improve the health care system and RH care delivery. UNFPA has supported the MINISANTE to develop policies and strategies related to its mandate and to improve RH service delivery in health facilities. It also advocates improvements in RH services and supports awareness-raising and education on FP and RH. The main focus of intervention at national and decentralised levels has been to increase the capacity of the health system to provide a high quality service for FP and RH. At national and decentralised levels the focus has been on an emergency response service, the prevention of maternal mortality and the prevention and treatment of obstetric fistula.

National Focus

UNFPA has one outcome for its national level work and one output.

Outcome: Improved quality, effectiveness and efficiency of the health system including nutrition, RH, maternal and child health and FP service.

Output: National policies, strategies and standards for health and nutrition, developed based on research and evidence and with a focus on equity and financing.

The UNFPA has supported MINISANTE to produce key policies and conduct the 2010 DHS. These activities link to the PD and Gender components, in terms of support for the 2010 DHS and the provision of gender-disaggregated statistical data to inform policy development and implementation. The 2010 DHS has been completed and a preliminary report published, with the full report due early in 2012.

35 Information in this Chapter is from documents provided by the CO in a resource file listed in the references. Other sources are fully referenced.
The policies that have been developed with UNFPA support are:

- *National Strategic Plan to Accelerate the Reduction of Maternal and Neonatal; Mortality and Morbidity 2008-12;*
- *Health Sector Strategic Plan 2009-12;*
- *National Strategic Plan for Condom Programming in Rwanda 2009-12;*
- *Adolescent Sexual Reproductive Health and Rights Policy 2011;*

These policies, plans and strategies, when implemented, will improve the quality, effectiveness and efficiency of the health care system in delivering reproductive and maternal health services. For example, the implementation of the *National Strategic Plan to Accelerate the Reduction of Maternal and Neonatal; Mortality and Morbidity 2008-12* has already contributed to reducing maternal mortality.

Technical assistance and financial support are provided for the development and implementation of a triennial action plan for maternal and child health (including a national midwifery programme to address the acute shortage of qualified midwives), research into the unmet need for FP (including cultural barriers), a revised *Reproductive Health Policy* and a web-based data base to improve the availability of quality statistical data. The Mother and Child Health Department at MINISANTE has been strengthened by funding additional staff, including a M&E Coordinator, a Financial Assistant and an Officer in charge of the Maternal Death Audit.

The indicator for this outcome is the proportion of the budget spent on health with an expectation that this will increase to 15 per cent in line with the *Abuja Declaration* (*Table 12*). The budget has remained stable over the *EDPRS* period with little indication that the Government intends to change it. However, Government commitment to improve health is evidenced by the significant progress made in improving health outcomes, with innovations like the mutual health insurance and elected CHWs playing an important role (Chambers 2011; Pose and Samuels, 2011).

It is unclear how increased spending would be a measure of improved quality, effectiveness and efficiency of the health care system. Increased spending does not necessarily improve quality, efficiency or effectiveness. We might have expected UNFPA to have used MMR as the indicator for this outcome given the focus of its work. We would note that the MMR has fallen dramatically in recent years and it is possible that the MDG for MMR will be achieved (*Figure 6*).

**Community Service Delivery**

The outcome focuses on improved health care at community level.

**Outcome 2: Improved Health Care, nutrition and hygiene practices at family and community levels**

The overall indicator for this outcome is the proportion of assisted deliveries. There has been a significant increase in deliveries in health facilities increasing from 52.1% in 2007/8 to 67% in 2010. Trend analysis suggests that the UNFPA target of 70% in 2012 will be met (see *Figure 29*).
Output: Increased capacity of the social and health system to provide a complete, integrated health-care package, including maternal, child, adolescent and youth health services appropriate to different levels.

UNFPA supports the delivery of a minimum health package in the community and in District Hospitals (see Table 8). The emphasis at district level is on staff capacity building and the provision of equipment and tools. The community package covers the same areas but with a slightly different emphasis. In HIV prevention, for example, the emphasis in hospitals is on VCT and the prevention of mother-to-child transmission (PMTCT) of HIV, while in the community greater emphasis is placed on the provision and promotion of condom use by young people. Support for the reduction of GBV has been through the One Stop Centres in DHs, while in the community it has been through school-based gender clubs. The community-level component also supports young people and former sex workers in income generating activities.

Ensuring that RH services are accessible in rural as well as urban areas is essential and this means encouraging women to use health facilities for antenatal care and delivery, as well as promoting modern contraception, not only amongst couples, but also amongst religious and traditional leaders. UNFPA has supported the establishment of 37 secondary FP Posts near Catholic Hospitals to these services within the community.

UNFPA has provided training, tools and supervision for CHWs in RH so that they can provide advice on contraception, antenatal-care and the need to give birth in a health facility. CHWs have also been trained in the causes and consequences of obstetric fistula and the importance of the referral system in the fight against fistula. The Obstetric Fistula Baseline Study has been completed in eight referral hospitals and 24 gaps were identified. As well as supporting the study UNFPA has provided training and equipment. Two-hundred and forty-five women benefited from fistula repair between January and September 2010.

UNFPA has also supported the introduction of the SMS Community Based Alert System which links CHWs with health centres and enables them to call for an ambulance in an emergency.

With other partners, UNFPA supported MINISANTE in organising a Mother and Child Health Week which sensitised mothers, fathers and youth about FP and the use of RH services. UNFPA has also supported the White Ribbon Alliance nationally, the launch and roll-out of the Campaign for Accelerated Maternal Mortality in Africa in 22 DHs in 2010 and the production and distribution of 2,050 copies of Safe Maternal and Child Health in Rwanda.
UNFPA technical and financial support to MINISANTE has institutionalised Maternal Death Audits, with 21 Government hospitals participating. Doctors and anaesthetists from the five district hospitals and their 50 health centres have been trained in EMONC, including third stage of labour. Support is being provided for the expansion of Kangaroo Mother Care. The district hospitals have been provided with ambulances and medical equipment to improve their capacity to respond to emergencies.

The UNFPA technical support and FP commodities are positively evaluated. In December 2009, 45 per cent of condoms recorded on the HMIS had been funded by UNFPA. In 2010, 6.6 million condoms were procured. Attention has been paid to the full range of contraceptive methods to give couples a choice of methods, and technical support to the introduction of depo-subQ Provera 104 was provided. During 2010 there was zero stock-out of contraceptives, and 400 training manuals and two FP management tools were distributed. Health cards for mothers for FP consultations, post-natal cards and pre-marital consultation cards were also distributed.

There are four indicators for measuring progress on this outcome:

1. No. of health facilities providing a complete and integrated service package including maternal, new-born, adolescent and child health services. The number increased by only three from a baseline of 497 suggesting little progress to date. There is no 2012 target.
2. No. of admissions for post-abortion care. There are no baseline data for this or 2012 target.
3. Proportion of births attended by a skilled healthcare worker. This has increased significantly in recent years (Figure 7) and the 2012 target looks likely to be achieved.
4. No. of health facilities offering a Youth Friendly Health Service. The number increased from 0 in 2006 to 13 in 2010 - an average rate of increase of three a year. Assuming that YFHS continue to be opened at the same rate then 20 could be achieved by 2012.

**CPD Output: Strengthened capacity for mobilisation of community organizations, faith-based organizations and traditional leaders**

A concern in Rwanda is the influence of religious leaders who are opposed to the promotion of modern contraception with the result that faith-based hospitals do not provide advice on, or supply, modern contraceptives. In 2007, 250 of the most senior religious leaders signed a declaration agreeing not to oppose FP promotion and HIV prevention (Solo, 2008). UNFPA has provided financial and technical support to sensitize 400 religious leaders, including Catholics, Methodists, Moslem and Protestants, about modern contraceptives.

Traditional healers who provide unsafe delivery service for mothers are also a cause for concern and have been trained as CHWs and sensitised to the importance of giving birth in a health facility.

There are two indicators for this output:

1. Percentage of umudugudu with at least two trained CHWs: 100 per cent of umudugudu have two trained CHWs so this target has been achieved.
2. Percentage of faith-based organizations promoting RH and FP at community level. The leaders of the main religious faiths have agreed not to oppose modern contraceptives and UNFPA take this as indicating they have achieved this output. However, the national religious leaders agreed to this in 2007 which predates the start of the 6th CP. In the M&E Framework 0 per cent is the target for 2008 with a 2012 target of 0 per cent which suggests that the target was intended to measure progress in community faith leaders promoting FP. There are no data on proportion of religious leaders promoting contraception at a local or national level.
HIV/AIDS
UNFPA provides technical and financial assistance to strengthen the resource capacity of the CNLS. This has included support for implementing its Strategic Plan, including ensuring the integration of the operational plans in the five ERPRS sectors. Support has also been provided for a comprehensive condom strategy produced in 2009, and a Condom Programming Officer was seconded from UNFPA to the CLNS, which was regarded as extremely useful (Key Informant). There was also support for a study of sero-surveillance amongst pregnant women and for the BBS sex worker study. A scale-up plan on HIV prevention care and treatment for sex workers has been produced and a training manual developed.

**CPD Outcome: People, especially youth and women, adopt protective behaviour and utilize prevention services**

There are three indicators for measuring progress towards achieving the outcome.

1. Per cent of youth (females and males aged 15-24 years) who have high risk sex and use condoms for HIV prevention. The per cent of male youth using condoms increased from 39.5 per cent in 2005 to 59 per cent in 2010 and for female youth from 24.4 per cent to 29.1 per cent. This remains well short of the 2012 target of 75 per cent for men and 60 per cent for women. The trend graphs suggest that the percentage will be 62 for male youth and 35 for female youth by 2012, someway short of the targets (Figures 16 and 17).

2. Percentage of youth, women, girls and men having used HIV prevention services (proxy indicator men/women 15-49 years who have at-risk sex and who use condoms). The portion of men declined between 2005 and 2010 from 40.9 per cent to 28 per cent, but increased for women from 19.7 per cent to 29 per cent. The 2012 target of 75 per cent for men and 60 per cent for women will not be achieved.

3. Prevention of mother-to-child-transmission of HIV declined marginally from 2.8 per cent in 2008 to 2.6% in 2010. It seems very unlikely that the 2012 target of 0.4 per cent will be achieved (Figure 11).

There is limited capacity at national level for the coordination of the HIV prevention response for most at-risk persons. At decentralised level UNFPA has provided technical support to the five districts to integrate RH/HIV/AIDS and income generating activities into their District Action Plans and for the sex workers programme in Rubavu and the Agaseke project in Kigali.

**CPD Output 3: Increased capacity of national and civil society institutions to provide participatory, youth friendly, HIV prevention services, including life skills and peer education for in- and -out of school youth**

There is evidence of a large unmet need by young people for SRH services, some evidence of reluctance to use public services and a need for the services to be provided at community level (Pandit-Rajani et al., 2010).
### Table 12: Showing progress against targets for reproductive health sub-component

<table>
<thead>
<tr>
<th>Outcome: Improved quality, effectiveness and efficiency of the health system including nutrition, RH, maternal and child health, and FP services</th>
<th>Baseline 2008</th>
<th>Status 2010</th>
<th>Target 2012</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPD Indicator: Percentage of government budget allocated to the health sector</td>
<td>9.5%</td>
<td>9.13%</td>
<td>15%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome: Improved health care, nutrition and hygiene practices at family and community levels</th>
<th>Baseline 2008</th>
<th>Status 2010</th>
<th>Target 2012</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPD Indicator: Percentage of assisted deliveries</td>
<td>52% 2007</td>
<td>67%</td>
<td>70%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Output: Increased capacity of social and health system to provide a complete health-care package, including maternal, child, adolescent and youth health services appropriate to different levels and targets</th>
<th>Baseline 2008</th>
<th>Status 2010</th>
<th>Target 2012</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPD Indicator: Number of facilities providing a complete and integrated service package including maternal, new-born, adolescent and child health services</td>
<td>497</td>
<td>500</td>
<td>Not Set</td>
<td></td>
</tr>
<tr>
<td>CPD Indicator: Percentage of obstetric gynaecological admissions for post-abortion care</td>
<td>Not Set</td>
<td>3%</td>
<td>Not Set</td>
<td></td>
</tr>
<tr>
<td>CPD Indicator: Number of health facilities with Youth Friendly Health Services</td>
<td>0</td>
<td>13</td>
<td>20</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPD Output: Strengthened capacity for community mobilisation of community organizations, faith based organizations and traditional leaders</th>
<th>Baseline 2008</th>
<th>Status 2010</th>
<th>Target 2012</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPD Indicator: Percentage of umudugudu with a least two trained community health workers</td>
<td>0%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>CPD Indicator: Percentage of faith-based organizations promoting reproductive health and FP at community level</td>
<td>0%</td>
<td>No data</td>
<td>10%</td>
<td></td>
</tr>
</tbody>
</table>

Source: UNFPA data file; ¹ Budget Statements for 2008, 2010/11; and EDPRS, 2008-12; ² 2010 DHS

36 The figures here are the portion of the Government budget allocated to health as in the Finance Law. UNFPA asked the Ministry of Health to calculate the portion of the Government budget spent on health taking account of what could be regarded as health spending by other ministries. The figure provided to us was 16.05% for 2010-2011. However, this has not been validated by the Ministry of Finance or the NISR.
UNFPA is a partner in the UN Joint Youth Programme which aims to support the MIJESPOC with a coordinated and effective HIV prevention response for young people\(^{37}\) and to improve access to YFHS. The capacity of the MIJESPOC to support YFCs has been strengthened by seven additional members of staff. HIV prevention learning materials and educational videos have been developed and distributed to 20 NGOs. UNFPA provides operational support for three YFCs to combine recreational facilities with sensitisation about SRH and GBV and supplies condoms. Training young people as peer educators is an important element of the service as are income generating activities. In 2009, 10,081 youth (aged under 25 years) received youth-friendly information, HIV testing and counselling. By 2010 more than 100,000 young people had accessed HIV prevention services in YFCs, through outreach activities and the Scouts. Youth activists have been trained to raise awareness on citizenship and SRH and a training manual produced to facilitate peer educators in providing out-of-school youth with information on FP, HIV prevention and SRH.

UNFPA has supported the development of a minimum package of YFHS and provides technical and financial support to ARBEF (an affiliate of the International Planned Parenthood Federation) to run two YFHS clinics providing FP, HIV and RH services to young people in Rusizi and Karongi. ARBEF provides services to unmarried women and adolescents as well as a general SRH service to all members of the community. Its services include condoms, contraceptives, voluntary counselling and testing for HIV (VCT), safe motherhood services and advocacy for safe abortion.

There are two indicators for this output.
1. No. of Youth Friendly Centres for HIV prevention increased from 9 in 2006 to 16 in 2010. The 2012 target of 14 has already been achieved.
2. No. of out-of-school youth who attended a YFC. There is no baseline and the 2012 target seems unrealistic and this information is not collected and reported on.

**CPD Output 5: Increased access to a comprehensive package of prevention services (information, education and communication; post-exposure prophylaxis; sexual and RH; sexually transmitted infection management; and voluntary counselling and testing) that addresses high risk groups and the drivers of the epidemic**

UNFPA has provided support to strengthen the capacity of NGOs and FBOs on FP, GBV and VCT in Karongi, Kayonza, and Muhanga and in the procurement of RH commodities. There was a campaign on HIV prevention and FP in 2009.

In 2009 UNFPA supported the World AIDS Campaign which focused on condoms. A 3-month long national mass media campaign was organised with the key message: *Condom as a means of dual protection, let’s access it, let’s use it: a fundamental right for all.* There has been a strong emphasis on female condom use. There is evidence that as a result of the campaign the distribution of male condoms increased by 55 per cent and female ones by 94 per cent (UNFPA MTR). In 2011, UNFPA provided financial support to strengthen the condom supply chain through the creation of a sustainable functional supply system by working with community-based groups to distribute condoms in the community on an on-going basis.

UNFPA has also provided support for the male circumcision programme. The Government is promoting male circumcision as part of a strategy to reduce HIV transmission.

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\(^{37}\) UN defines youth as aged 15 to 24 years.
The RALGA is responsible for the development of an integrated package of support and sensitisation for vulnerable groups for HIV prevention, GBV prevention and response and RH in the five focus districts. The groups to be targeted are sex workers, youth, women engaged in cross-border trade and adolescent mothers.

There are three indicators for this output:
1. Percentage of young people aged 15-24 who are knowledgeable about where to obtain condoms. There are no data yet available to measure this target. The DHS data will be available in early 2012.
2. Percentage of population who are aware of their individual HIV status. The most recent data are for 2008 when the figure was 19.6 per cent, showing no improvement from the 2005 figure. The 2012 target of 40 per cent of the adult population knowing their status seems unlikely to be achieved as insufficient people are having a HIV test.
3. Number of male and female condoms distributed increased from 7.5 million in 2005 to 24.6 million in 2010. The latter figure includes those distributed by the Government and social distribution. However, the 2005 figure seems to be for government only. The 2012 target of 12 million was achieved in 2010 for government distributed condoms alone (Figure 19).

4.3 Population and Development

4.3.1 Relevance

Assess the extent to which the 6th CP for PD has contributed to the defined results of the United Nations Development Assistance Framework 2008-2012 and to national priorities as set out in the EDPRS 2008-2012 and the MDGs are still relevant and have contributed to solving the problems and meeting the needs of beneficiaries.

The Population and Development sub-component supports the UN policy in Rwanda of strengthening the legislature and contributes to the:

- Government commitment to use high quality data, including gender-disaggregated data, to inform decision-making;
- Decentralisation policy and strengthens the availability of data for policy formation and implementation at local level and the capacity of local officials to use population data;
- Achievement of all MDGs - high quality data are essential to inform policy formation and planning and to measure progress at all levels.

The PD sub-component also connects with the other two sub-components in terms of providing quality data for gender and RH as well as building capacity to use the data.

4.3.2 Effectiveness to date

Assess the extent to which the planned outcomes in PD have been achieved by the 6th CP up to 2011 and provide a trend analysis to June 2013

The Population Policy has been drafted and is pending Cabinet approval. The Policy shows a clear relationship between population growth and poverty. Whilst the technical staff and their managers in the MINECOFIN and the Parliamentary Forum on Population recognise an urgent need for the policy to be adopted and an implementation strategy developed there have been delays in the Policy being approved by Cabinet. UNFPA is the only development partner providing support for the Population Desk.

UNFPA in collaboration with UNDP and UNICEF is providing the Ministry with technical and financial support to set up a national M&E system and build operational capacity. The subsystem will support the development of EDPRS 2.
### Table 13: Showing progress against targets for HIV/AIDS sub-component

<table>
<thead>
<tr>
<th>Outcome: People, especially youth and women, adopt protective behaviour and utilize preventive services</th>
<th>Baseline 2008</th>
<th>2010</th>
<th>Target 2012</th>
<th>Status&lt;sup&gt;38&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPD: Percentage of females and males (15-24 years) using condoms for HIV prevention</td>
<td>39.5 M 26.4 W</td>
<td>58 M 29.1W</td>
<td>75% M 60% W</td>
<td>Green “On Track”, Red “Off Track”, Blue “Insufficient Data”</td>
</tr>
<tr>
<td>CPD Output: Mother-to-child-transmission</td>
<td>2.8% in 2008</td>
<td>2.6%</td>
<td>0.4%</td>
<td>Red “Off Track”</td>
</tr>
<tr>
<td>CPD Output: Percentage of youth, women, girls and men having used HIV prevention services (proxy indicator men/women 15-49 years use condoms)</td>
<td>M 40.9% W 19.7%</td>
<td>M 28% W 29%</td>
<td>75% M 60% W</td>
<td>Blue “Insufficient Data”</td>
</tr>
</tbody>
</table>

### Output: HIV response plans and coordination mechanisms established and operational at national and decentralised levels

### Output: Increased capacity of national and civil society institutions to provide participatory, youth-friendly, HIV prevention services, including life skills and peer education for in-and out-of-school youth

| CPD: Number of youth-friendly centres for HIV prevention<sup>39</sup> | 9 | 16 | 14 | Green “On Track” |
| CPD: Number of out-of-school youth that attend youth-friendly service centres | To be determined | | 300,000 in 2012 | Blue “Insufficient Data” |

### Output: Increased access to a comprehensive package of prevention services information, education and communication; post-exposure prophylaxis; SRH; sexually transmitted infection management; voluntary counselling and testing that addresses high-risk groups and the drivers of the epidemics

| CPD: Percentage of females and males aged 15-24 years knowledgeable about where to obtain condoms | M 73% W 37% 2005 | | 90% M 60% W | Blue “Insufficient Data” |
| CPD: Percentage of population aware of individual HIV status | 20% 2005 | 19.6 2008 | 40% | Blue “Insufficient Data” |
| CPD: Number of male and female condoms distributed | 7.5 million 2006 | 24.6 million public and social | 12 million annually | Green “On Track” |
| CPD: Percentage of young people aged 15-24 who practice high-risk sex during last 12 months and who used a condom for last sexual encounter | M 40% W 26% 2005 | M 58% F 29% | 75% M 50% W | Red “Off Track” |

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38 Green ‘On Track’, Red ‘Off Track’, Blue ‘Insufficient Data’

39 UNFPA provides direct support for 3 YFCs at Gicumbi, Karongi and Rusizi and two ARBEF Clinics at Karongi and Rusizi as well as technical support to the MIJESPOC.
**CPD Outcome: The use of high gender quality, disaggregated data guiding policy and socio-economic planning**

There are two indicators for the Outcome:

1. No. of surveys, studies, assessments and reports produced for policy and planning by the national statistical system. The target is 40 by 2012 with a baseline of 17 in 2006. Five were completed between 2006 and 2010, two were completed in 2011 with two due to be completed by the end of 2012. Thus the target will not be met and NISR does not have the capacity to increase the number of surveys it undertakes.

2. No. of District Plans based on disaggregated data. The 2012 target of 30 has already been met. All districts use disaggregated data in their plans.

**CPD Output: Information systems, including for population data, are fully developed and operational in the public sector**

National capacity to produce, analyse and use high quality statistical data is critical. Evidence is needed to guide public policy and socio-economic planning and it should be readily available and easily accessible. However, staff need to be appropriately trained and equipped to collect, analyse and use data.

UNFPA has provided technical and financial support to NISR and to five districts to support the collection and use of high quality disaggregated data to inform policy development and implementation. They have also provided support to the five districts as well as to MINISANTE in using population data to inform policy and practice.

Three main projects have been supported by UNFPA with regard to data collection and dissemination: Civil Registration; the Integrated Management Information System (IMIS); and the 2012 Population and Housing Census.

A national Civil Registration and Vital Statistics System has been put in place with UNFPA support and vital and social statistics are being collected at the sector level using the new system. Technical assistance to the NISR has been provided by UNFPA and in the five districts for training in data collection and use, as well as computers for the districts. The capacity of the civil registration personnel (civil registration officers, executive secretaries and district statisticians) has been developed to use the Civil Registration and Vital Statistics System for planning and poverty mapping. The capacity of district planners has been strengthened in integrating population issues in development plans and budgets. As a result, 2,080 registers are now available in all 416 sectors for quality data tracking on civil registration and vital statistics. A total of 150 computers, 60 printers, 60 uninterruptible power supplies (UPS) have been provided to support civil registration.

UNFPA has supported the NISR to put in place the IMIS - a tool that administers large volumes of census and survey micro data with hierarchical (geographical) structure down to the smallest segment of the census administrative area. The IMIS is now available on the NISR Intranet and can be accessed at [http://www.imisrwanda.gov.rw](http://www.imisrwanda.gov.rw). Household Survey 2005/6, DHS 1992, 2000 and 2005, SPA and General Population and Housing Census (GPHC) 2002 and economic statistics data sets have been uploaded and are fully accessible. New data sets will be added as they become available.

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41 DHS 2010, Establishment Survey
UNFPA and other UN agencies have provided technical and financial support to NISR for the 2012 Population and Housing Census which is on track to be achieved. UNFPA provided technical advisors, equipment and funded the pilot. The technical team is in place, including a cartographer who has trained NISR staff in cartography and mapping activities. UNFPA has secured US$ 2.5 million to support this work, of which 75 per cent has already been disbursed.

The vital registration system is operational, but at district level continuing support will be necessary to ensure the collection of quality data and that data are used to inform planning.

Capacity of members of the RPRPD, one of the IPs, has been developed so that Members of Parliament can provide authoritative advice on population and RH issues and comment authoritatively on bills that come before the House. They have also been supported in raising the awareness of citizens, including religious leaders and out-of-school youth, on population, gender and RH issues.

There are three outcome indicators for this outcome (Table 14).

1. No. of published documents and studies based on RH, PD and gender data. The baseline is 0, the target 10 and the number published by 2010, six. If documents and studies continue to be published at the same rate the target looks likely to be achieved. Note that it is unclear how the judgement is made that the documents and studies are based on data or what the inclusion criteria are for documents and studies.

2. No. of districts with Civil Registration systems established and functioning. The baseline is 0 and the 2012 target is 17. By 2010, five districts (the ones UNFPA supports) had operational systems. Although the focus since 2011 is on the five districts in the Western Province, civil registration was supported in other districts before 2011 and 416 sectors of 30 districts received registrars for vital events registration and 160 computers were provided to 160 sectors. UNFPA is working with UNICEF and Belgian cooperation to support civil registration and the target of 17 districts is likely to be met by 2012.

3. No. of districts with data bases with disaggregated data available by gender, age and disability used for poverty mapping and planning. The baseline was 0 and the 2012 target 17. In 2010 the number was 0. There seems little prospect that the target will be achieved by 2012.

Table 14: Outcome indicators Population and Development component

<table>
<thead>
<tr>
<th>CPD Outcome: The use of high quality, disaggregated data guiding policy and Socio-economic planning</th>
<th>Baseline 2008</th>
<th>2010</th>
<th>Target 2012</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPD: Number of surveys, studies, assessments and reports produced for policy and planning by the national statistical system</td>
<td>17 2006</td>
<td>5 since 2006</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>CPD: Number of District Plans based on disaggregated data</td>
<td>0</td>
<td>30</td>
<td>30</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPD Output: Information systems including for population data are fully operational in the public sector</th>
<th>Baseline 2008</th>
<th>2010</th>
<th>Target 2012</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPD: Number of published documents and studies based on RH, population and development, and gender data</td>
<td>0</td>
<td>6 2008</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>CPD: Number of districts with civil registration system established and functioning</td>
<td>0</td>
<td>5</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>CPD: Number of districts with local disaggregated database used for poverty mapping and planning, with an emphasis on young people, women and people living with disabilities</td>
<td>0</td>
<td>0</td>
<td>17</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPD Outcome: an effective educational management system in place</th>
<th>Baseline 2008</th>
<th>2010</th>
<th>Target 2012</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPD: Percentage of educational institutions using an IMS in planning</td>
<td>0</td>
<td>0</td>
<td>No target</td>
<td></td>
</tr>
</tbody>
</table>
**CPD Outcome 6: An effective educational management system is in place**

We can find no evidence that UNFPA has contributed to the development of the Educational MIS since the start of the 6th CP. The EMIS is not yet operational.

### 4.4 Gender

#### 4.4.1 Relevance to date

*Assess the extent to which the 6th CP for gender has contributed to the defined results of the UNDAF 2008-2012 and to national priorities as set out in the EDPRS 2008-2012 and the MDGs are still relevant and have contributed to solve the problems of and meeting the needs of beneficiaries.*

This component contributes to the achievement of MDG3 and to MDG1b. In Chapter 4 we demonstrated how this component contributes to the defined results of the UNDAF and to EDPRS and the strong commitment of the government to gender equality and the promotion of women. However, there remains a need for building capacity at central and decentralized level in gender impact analysis and the collection of gender disaggregated data. We have also demonstrated that many ordinary Rwanda women have yet to benefit fully from the Government policies. GBV remains a serious problem and nearly 60 per cent of women work as dependent family workers.

#### 4.4.2 Effectiveness to date

*Assess the extent to which the planned outcomes in gender have been achieved by the 6th CP up to 2011 and provide a trend analysis to June 2013.*

The UNFPA Gender Component is in line with government policy for gender equality and the empowerment of women. It is also in line with the Gender Policy which accords MIGEPROF the responsibility of ensuring that gender is mainstreamed in all Government policies and sectors. It also supports the Government’s commitment to collect and use gender-disaggregated data through the establishment of the GMO and its policy to introduce gender-sensitive budgeting. The Gender component links with the RH and PD components with an emphasis on the use of high quality disaggregated data in policy development and implementation and awareness-raising of youth about SRH and GBV. UNFPA is the lead UN agency for GBV in relation to health. There is a strong emphasis on awareness-raising and capacity-building, including women in government and Parliament and the National Women’s Council (NWC).

**CPD Outcome 8: All public and private institutions apply gender-equality principles and standards in their performance, practices and behaviour**

There are two indicators for this outcome:

1. No. of public and private institutions applying the 30 per cent quota for women. No base line or target was set. The 2010 figure is 34 per cent based on a report from the GMO (Table 4). The quota only legally applies to elected positions in the public sector.

2. Percentage of institutions with transparent, non-discriminatory promotion systems. The base line is 44.4 per cent, but no target was set. The 2010 figure 55.6 per cent. However, it is not clear which institutions are included and how the information is collected and verified.

**CPD Output: The institutional capacity of key development actors is strengthened in the areas of coordination, gender-based analysis, planning, policy formation, monitoring and evaluation.**
The main focus of UNFPA’s work in gender has been technical support for capacity building of the national gender machinery working with the MIGEPROF, the Forum of Women Parliamentarians, the NWC and the GMO. The aim is to raise awareness of the importance of gender equality and the empowerment of women and to equip the Government at central and decentralised levels, community leaders and CSOs to ensure gender mainstreaming and the use of gender-disaggregated statistics in policy development and implementation. The 6th CP has supported capacity building in MIGEPROF and beyond, including community leaders, religious leaders and ordinary Rwandans. Pro-Femmes, NWC and other women’s organizations have been trained in advocacy for the involvement of youth and women in decision-making. A specific focus has been on GBV and the use of results-based M&E in gender issues.

A strategic partnership between MIGEPROF, MINECOFIN, UNFPA and UNWomen was established in 2008 to promote gender mainstreaming and gender-responsive budgeting (GRB) in public and private institutions. In 2009, 129 planning and budgeting officers from ministries and districts were trained in gender mainstreaming and GRB. In 2010, training on GRB for francophone African countries was provided by MINECOFIN supported by UNFPA. UNFPA supported a systematic capacity-building plan on gender mainstreaming and gender equality for Gender Focal Points (which is still on-going) from ministries, universities and key development partners. In 2008, 59 Gender Focal Points were trained and in 2010, Directors of Human Resource and Deans from 18 higher education institutions were trained in gender mainstreaming, GBV and advocacy techniques. Religious leaders have also received training in the integration of gender equality principles in programming. Ninety-five leaders were trained by MIGEPROF in 2008/9, with support from UNFPA.

UNFPA supported the establishment of the GMO, which derives its mandate from the National Gender Policy and the Rwandan Constitution and serves as a Gender Observatory to monitor gender compliance in different institutions in Rwanda. UNFPA supported the GMO in monitoring the local election results in 2010 and has provided training in M&E, gender audit and gender monitoring for staff.

Twenty-nine gender clubs in secondary schools and 12 clubs in higher education institutions have been supported with training and equipment, and members have been sensitised on gender issues, including GBV and SRH.

UNFPA participated in advocacy for, and the review of, the Gender Based Violence Law which came into force in 2009 and has supported the development of the GBV Policy and Strategic Plan, which were adopted in 2011. The law is comprehensive, including psychological and economic as well as physical and sexual violence. Through the joint GBV initiative (with UNICEF and UNWomen) there has been an increased focus on service delivery in the health sector for survivors of GBV and strengthened links between health and legal service providers and paralegals.

With support from UNFPA, UNICEF and UNWomen, the first Isange One Stop Centre was established at Kacyiru Police Hospital in Kigali in July 2009. It provides medical, psycho-social, medico-legal and police/legal services in one place. A second One Stop Centre was opened at Gihundwe Hospital in Rusizi in 2010. UNFPA has also supported MINISANTE to develop a manual for the clinical management of GBV survivors, which sets out clearly the division of labour between the decentralized Health Centres, District Hospitals and Referral Hospitals. UNFPA is now
working closely with MINISANTE to develop a national scale-up strategy for the One Stop Centres, including a training package for all future service providers.

As part of the joint GBV initiative, UNFPA and other UN agencies supported the development of guidelines and the establishment of GBV/Child Protection Committees nationwide. These Committees are responsible for developing prevention strategies locally and providing a referral system for survivors of GBV. In 2010, UNFPA and other UN agencies partnered with the Rwandan National Police to deliver an international conference on *The Role of Security Organs in Ending Violence against Women and Girls* in the framework of the UN Secretary General’s campaign on *Ending Violence against Women*.

UNFPA provided support to guidance for newly married couples (45 in 2010) on the roles and responsibilities of men and women in FP, the promotion of gender equality and non-violent conflict resolution as an alternative to GBV. UNFPA also worked through a local CSO to raise awareness of historically marginalized people (“indigenous groups”) on FP, RH, GBV and HIV prevention.

UNFPA has strengthened the capacity of local authorities to coordinate and implement their priorities in the area of gender. RALGA is now the responsible IP for this. UNFPA in partnership with the MIGEPROF and the Chamber of Women Entrepreneurs supported 15 income generating projects designed by individual women or women’s cooperatives. The first evaluation after three months shows that the projects had been successfully set up and were operational. Women testified that this has empowered them, promoted more understanding with their husbands and given them an opportunity to tackle RH and FP issues in their families.

Vulnerable women have been empowered through the *Agaseke* project supported jointly by Kigali City Council and nine UN agencies, including UNFPA. They have been sensitised on SRH and encouraged to use contraception and other medical services. They are also trained in income generating activities to enable them to provide for themselves and their families.

There are two indicators to measure this output:

1. **No. of development partners with Gender Focal Points trained and equipped with gender planning tools.** The base line is 0 and the target 120. The 2010 figure is 33.3 per cent. It is not clear if this is a percentage of the 120, or of partners with a trained and equipped Gender Focal Point. If it is the former, it is unlikely that the target will be achieved by 2012.

2. **No. of gender-sensitive policies and programmes in SRH and in PD approved from 2008 onwards.** The baseline is 0 and the target is that four sectors will be gender responsive. The 2010 figure is two. The CPD refers to number of gender sensitive policies in SRH and development and the 2012 target to sectors which are the ones where gender informed budgeting is being implemented. It is unclear as to how the output will be verified. Without further information it is not possible to determine if this output will be met.

### Table 15: Outcome Indicators Gender Component

<table>
<thead>
<tr>
<th>Outcome : All public and private institutions apply gender-equality principles and standards in their performance, practices and behaviour</th>
<th>Baseline 2008</th>
<th>2010</th>
<th>Target 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome Indicators</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPD: Number of public and private institutions applying the 30% quota</td>
<td>Not set</td>
<td>34%</td>
<td>Not set</td>
</tr>
<tr>
<td>CPD: Number of institutions with transparent, non-discriminatory promotion systems</td>
<td>44.4% 2008</td>
<td>55.6%</td>
<td>Not set</td>
</tr>
</tbody>
</table>
### 4.5 Impact

**Assess the changes that the 6th CP has brought about for beneficiaries and the extent to which it has meet their needs**

Impact measures the positive and negative changes produced by the 6th CP’s interventions, directly or indirectly, intended or unintended. It is important to consider what has happened as a result of the programme and what real difference the programme has made. It is difficult to attribute impact to the 6th CP and we can only note the improvement of the impact indicators in most cases at the country level. Indicators are available for the five districts that UNFPA is supporting with an integrated package at district and DH levels. However, the UNFPA funding is only a small element of total spending.

Advocacy for the vulnerable and less powerful can be a key element to bring about behaviour change. Impact is the actual difference that the change makes to people’s lives - to their well-being individually and collectively.

**There is evidence of impact of the 6th CP, even though it has been running for less than four years. Data suggest that further progress will be achieved by the end of the programme.**

In Chapter 2 we discussed the positive progress made towards achieving EDPRS and MDG 2015 targets in the areas in which UNFPA works. However, not all of the UNFPA targets will be achieved fully and in some cases data are not yet available to measure progress.

Small projects may have significant impact on the lives of the beneficiaries even if the impact is not reflected in improvement in global indicators. In the 6th CP, the Sex Workers Project is an example of this. Key informants and beneficiaries indicated the positive impact it has had on the lives of former sex workers who participated in it (*Key informant; FGD*).

The work that UNFPA has done in providing training in results based M&E for its IPs has also had a positive impact on their capacity to monitor and evaluate programme implementation. Here the focus is on the changes in impact indicators for each component and later we provide a contribution analysis of results achieved by the three components.

**Impact on reproductive health**

- Increase in membership of the community health insurance (CHI) with the 2011 budget introducing graduated payments with the poorest being exempt from paying the premium and increasing access to universal coverage (*Figure 5*). The beneficiaries in FGDs\(^44\) were very appreciative of the CHI, but said it was difficult for them to afford to pay the premium.

\(^{43}\) The sectors are Agriculture, Education, Health and Sanitation. Information provided by GMO.

\(^{44}\) The list of FGDs is in Annex 3.
A significant decline in maternal mortality with the data from the 2010 DHS awaited to show if Rwanda is on track for the MDG target (Figure 6).

A significant increase in the proportion of women with a skilled birth attendant present at delivery – increasing from 52.1 per cent in 2007 to 69 per cent in 2010. The mothers in FGDs said they were aware of the importance of delivering their babies in health facilities, but pointed out that they were fined if they did not do so.

An increase between 2008 and 2010 in the proportion of pregnant women attending four or more antenatal care visits from 23.9 per cent to 35.4 per cent and a decline from 2.7 to 1.8 in women who did not attend any antenatal care (Figure 10). The women who took part in the FGD indicated that they now understood why it was important to attend for antenatal care, but they also pointed out that one reason women attended was because of the fines if they did not. They also said that the antenatal care they received was good and included preventive measures as well as advice on keeping healthy.

An increase in married couples’ use of modern contraception from 27 per cent in 2008 to 45 per cent in 2010 and an increase amongst young women (Figures 11 and 12). However, there remains an unmet need for contraception of 44 per cent amongst married women aged 15-49 years. The beneficiaries in our FGDs said that many women now use contraceptives because of sensitisation by CHWs and from the radio. However, they said that they would not use them if they were not provided free. There was a preference for injectable contraception as the participants said they forgot to take the pill and their husbands would not use condoms.

All the informants in the community to whom we spoke said that condoms were easily available but that female ones were available only at health centres. Stock-out is not a problem.

High and increasing levels of knowledge amongst men and women of safe sex and HIV prevention behaviour, including amongst young men and women (Figures 13-16).

A decrease in the numbers of young men and young women who engage in unsafe sex and used a condom at their last sexual intercourse, although the UNFPA target is unlikely to be achieved (Figures 17 and 18).

Capacity building of health care workers, including CHWs, nurses and doctors in preventing maternal deaths and obstetric fistula care. The CHWs interviewed seemed knowledgeable about FP and SRH, but said they needed more training.

Positive impact on the lives of: i. women who have had a fistula repair, and ii. former female sex workers and youth, who have benefited from training for income generation. Sensitisation about FP and safer sex was seen as very important by the former sex workers, who said they had not previously had any such information. This comes across very clearly in the FGDs and key informant interviews. Former sex workers supported by the project have been able to pay for mutual health insurance for themselves and their families.

**Impact on Population and Development**

- A decline in the TFR from 5.5 in 2008 to 4.6 in 2010 with the trend line suggesting the EDPRS target of 4 should be met (Figure 19).
- The introduction of the National Strategy for the Development of Statistics.
- The development of the Population Policy – UNFPA is the only development partner supporting this work.
- YFHS were viewed positively by IPs, managers and clients, especially in terms of awareness raising and supply of condoms.
• The use of quality statistical data in policy development and implementation at central and decentralised levels. The district and hospital staff we interviewed said they use statistical data in planning, although a need for more training was expressed including for vital registration.
• Capacity building of Members of Parliament on population issues has enabled them to advocate for population issues and scrutinise legislation.

Impact on Gender
• The introduction of gender-informed budgeting in four sectors.
• The increase in the number of women elected to serve in Senate from 30 per cent in 2008 to 39 per cent in 2011.
• The GBV Law, Policy and Strategic Plan and the introduction of the One Stop Centres have brought together health care professions, the police and others to fight GBV and were seen as having a positive impact on the lives of survivors of GBV.
• Capacity building of women Ministers and Members of Parliament in understanding gender issues and the ability to undertake gender impact analysis.
• Capacity building of young men and women to act as peer tutors for SRH.
• Most of the IPs interviewed had a trained Gender Focal Point who had gender planning tool, but for more training and better tools was thought necessary.

4.6 Assessment of UNFPA by Implementing Partners and other key informants
Generally IPs\textsuperscript{45} thought that UNFPA was performing well and it was compared favourably with other ODPs, including other UN agencies. Its programme and area of work was seen as important and in line with government policy. A number of positive comments were made and some concerns were raised.

Financial resources
• Providing funds to IPs was seen as important: UNFPA was identified by some as the only donor that gives money directly to them. This gave greater ownership and control and reduced transaction costs.
• Districts were very appreciative of support from UNFPA, especially because they have a say in what and how much was funded. They welcomed the bottom-up approach whereby UNFPA looks at plans, identifies what is related to its mandate and funds it within the limits of its financial capacity. However, whilst central Government IPs also referred to working with UNFPA to identify what it will fund, there was concern about lack of Government involvement and insufficient control by IPs.
• Some concerns were expressed about delays in disbursement of funds and uncertainty about the funding situation at the beginning of the financial year. The difference in the financial years used by UNFPA and the Government was seen as problematic. However, consistency was seen as positive, with continuity of funding from one UNFPA CP to the next, and one IP praised UNFPA for quick disbursement.
• Funding was often seen as inadequate to complete implementation. One district pointed out that they had computers but also needed training and the funds available were inadequate.
• District Hospitals and districts where UNFPA is withdrawing support experienced difficulties in accessing funds to cover previous UNFPA supported work. However, MINISANTE and

\textsuperscript{45}The list of IPs and other key informants interviewed can be found in Annex 3.
MINECOFIN agree that UNFPA had consulted them about withdrawing and accept that it is Government responsibility to mobilise funds for future work.

- Annual funding makes it difficult to recruit and retain competent staff because of short-term contracts.

**Human resources**

- One IP suggested that UNFPA staffing levels were inadequate and one IP mentioned that they would like to be involved in the appointment process of UNFPA technical staff to ensure that the right person was appointed.

**Monitoring and evaluation**

- Support for RB M&E and collection and use of statistical data was seen as necessary and relevant, as were field visits. However, all the districts needed more training on vital registration and staff at District Hospitals and Health Centres need training on HMIS.
- Computers provided by UNFPA were seen as an important resource that facilitated the implementation of the vital registration project.
- Statistical data are used for planning, but financial constraints may limit the full implementation of plans.

**One UN**

- Informants had mixed views of One UN, although UNFPA was seen to be performing well. Some felt it was uncoordinated and others saw it as an improvement, especially in terms of the mobilization of resources and the avoidance of duplication of reports. Joint initiatives were seen to have helped the mobilization of One Funds. The Joint Youth initiative was noted for slow mobilisation of resources, despite being a priority area.

4.7 **Recommendations to UNFPA by Implementing Partners for 7th County Programme**

The key stakeholders and IPs interviewed had a number of suggestions for priorities for the 7th CP – often related to their area of interest. However, a near universal comment was that UNFPA should be much more focused on areas where it can bring real benefit to beneficiaries and demonstrate impact. The comparatively small amount of funding needs to be well directed for maximum effect with clear and measurable outputs. Other suggestions were that UNFPA should:

1. continue to support One Stop Centres;
2. provide technical support for medical equipment, training of medical personal and community support;
3. train and build capacity of staff in the use of statistical data in planning and vital registration;
4. support obstetric fistula treatment and rehabilitation: the women who had had fistula repair suggested that UNFPA should train more doctors so more women could benefit, train CHWs to advise women with fistulae on management of the condition and provide follow-up support to women who have had fistula repairs;
5. focus on youth as a priority group and YFHS;
6. support PMTCT, CHWs, Female Sex Worker Project and build capacity of IPs;
7. provide further training and support for income generation activities for youth and former female sex workers.
4.8 Sustainability

**Assess the extent to which the benefits are likely to continue beyond the end. Has UNFPA been able to support its partners and beneficiaries in developing capacities, mechanisms to ensure the durability of the effects?**

Sustainability is concerned with measuring if the benefits achieved by the programme activities are likely to continue should support be withdrawn. Although Rwanda has a policy objective of becoming less reliant on aid in the medium term, for the immediate future the country will continue to rely on significant financial and technical support. So the question is to what extent the activities undertaken as a part of the 6th CP are sustainable, or are candidates for scaling up? Sustainability can be measured by individual and institutional behavioural change. Have behaviours become routine and embedded in everyday practice?

The main strength of the 6th CP in terms of sustainability is the synergy between Rwanda’s development priorities and the mutually consultative approach adopted by UNFPA. We were repeatedly told by IPs that if UNFPA withdrew funding then they would have to seek funding from elsewhere. The activities that UNFPA fund in Gender, RH and PD were seen as essential. The link is further strengthened by the collaborative District Annual Work Plans being developed. UNFPA agrees with the districts, NGOs and CLNS which activities in their work plans it will fund. UNFPA funds activities centrally and in DHs that are included in the Health Strategic Plan. For the PD component, UNFPA is funding planned and prioritised projects.

There is evidence that changes are becoming institutionalised within organizations. A review of the *District Performance Contract 2011-2012* for UNFPA supported districts shows that they all included targets for RH (Table 16). The findings from our fieldwork also suggest the use of population data for planning is becoming standardized in District Hospitals and in the community although further support is needed. The IMIS is up and running and accessible on the Internet, but more data sets need to be added. The Census is at an advanced stage and the pilot conducted.

<table>
<thead>
<tr>
<th>District</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Karongi</td>
<td>Number of health centres with maternity wards increased</td>
</tr>
<tr>
<td></td>
<td>Number of women giving birth in health centres increased</td>
</tr>
<tr>
<td></td>
<td>100 per cent membership of Mutual Health Insurance</td>
</tr>
<tr>
<td></td>
<td>Number of couples using modern methods of contraception increased</td>
</tr>
<tr>
<td></td>
<td>Increase in number of people voluntarily testing for HIV</td>
</tr>
<tr>
<td>Ngororero</td>
<td>100 per cent membership of the Mutual Health Insurance Scheme</td>
</tr>
<tr>
<td></td>
<td>Number of women giving birth in Health Centres increased</td>
</tr>
<tr>
<td></td>
<td>Increase in number of people voluntarily testing for HIV</td>
</tr>
<tr>
<td>Nyamasheke</td>
<td>100 Per Cent Membership of Mutual Health Insurance</td>
</tr>
<tr>
<td></td>
<td>Number of couples using modern methods of contraception increased</td>
</tr>
<tr>
<td></td>
<td>Increase number of Youth Friendly Centres and increase service to youth</td>
</tr>
<tr>
<td>Rubavu</td>
<td>Number of couples using modern methods of contraception increased</td>
</tr>
<tr>
<td></td>
<td>Increase in number of pregnant women and their partners who voluntarily take an HIV test.</td>
</tr>
<tr>
<td>Rusizi</td>
<td>Number of couples using modern methods of contraception increased</td>
</tr>
<tr>
<td></td>
<td>Number of women giving birth in Health Centres increased</td>
</tr>
<tr>
<td></td>
<td>Increase in number of people voluntarily testing for HIV</td>
</tr>
</tbody>
</table>

Source: District Performance Contracts 2011-2012, Ministry of Local Government

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46 This is now a realistic target as the 2011-2102 Finance Act introduced a graduated payment scheme with communities identifying those too poor to pay the premiums for free membership.
Positive changes in the adoption of safe RH practices have been noted. The remarkable increases in the numbers of married couples using modern contraception and in women giving birth in health facilities bear witness to this. Maternal death audits and surgical provision for fistula have become integrated into hospital systems. The emergency response has improved through the provision of ambulances and SMS. There is also evidence of increased condom use by young people who engage in unsafe sex.

Three of the projects that UNFPA supports are already being scaled up, or are regarded as needing to be scaled up. These are the One Stop Centres for GBV, YFCs (as youth are a high priority group for the Government, especially to build their capacity in income generation) and the ex-Sex Worker Project to increase skills in safer sex and provide sex workers with an alternative means of income.

Technical support for capacity building is funded across the 6th CP, ranging from training women leaders and Parliamentarians in gender impact analysis to training CHWs to support women in the community. The ‘trainer of the trainers’ approach supports sustainability – for example, training peer educators in SRH and Parliamentarians to enable them to sensitize faith leaders on population and SRH.

Health care is affordable for the majority of the population through the Mutual Health Insurance Scheme and those who are destitute are exempt from premiums.

However, there are risks to sustainability and a focus on sustainability should be included in future UNFPA planning documents. The 6th CP, even with the more focused strategy, is rather fragmented, and funds are sometimes insufficient to meet needs for capacity building and equipment. For example, districts need more support for introducing the vital registration system and for capacity building in gender. The withdrawal of UNFPA support in the districts in which it works would severely set back the full introduction of the system and ARBEF said their two clinics would close if UNFPA withdrew funding.

Trained CHWs are in place and the Smart SMS system is being scaled-up. However, CHWs are elected volunteers and so are liable to replacement, necessitating training of newly elected ones although the formation of community health workers into worker cooperatives to enable them to generate an income may provide more stability.

Contraceptives are provided free and this provides a strong incentive to use them. The women in our FGD during fieldwork said they would not use contraception if they had to pay for it. Ninety per cent of demand is met through donation and social marketing (Pandit-Rajani et al., 2010). Eighty-eight per cent of the FP market is provided by the Government and the social sector (IDHS 2007). This is not sustainable in the medium term and consumer segmentation needs to be developed, with the private sector supplying those who can afford to purchase. Although the adoption of FP seems to have become embedded in one of the fieldwork sites, we were told that there was strong pressure from local protestant religious leaders not to use FP and that this was having a negative impact on take up.

There is a severe shortage of skilled and competent Rwandans and a high turnover in staff, and the public sector, in common with all employers, finds it difficult to recruit competent staff. This means that there is an on-going need to build local capacity with technical assistance.

47 The contracts are in Kinyarwanda.
5. Strategic Positioning

5.1 Corporate alignment

5.1.1 Vulnerable groups
The UNFPA CO supports a number of vulnerable groups especially in the Gender and RH components. The main UNFPA activities in support of vulnerable groups have been:

- Sex Worker Project in Rubavu and the development of a scaled up national programme;
- vulnerable poor families, young women and HIV-positive mothers in partnership with the IMBUTO Foundation, especially the Agaseke project;
- support for the creation of a gender-based violence desk at the National Police Headquarters in Kigali in collaboration with UNDP, UNICEF and UNWomen;
- One Stop Centres in Kigali and Rusizi for survivors of GBV and capacity building for DHs to provide a comparable service;
- Village of Hope, in collaboration with UNAIDS, UNDP, UNWomen and the WFP, provides a refuge for the most vulnerable and marginalized groups;
- out-of-school youth in raising awareness of safer sex, RH and FP;
- family hygiene kits developed in collaboration with the Women’s National Council to returnees, internally displaced women and women living with disabilities;
- building capacity for disaster management with respect to training on RH and rights for women and men, boys and girls in emergency situations including for vulnerable women;
- awareness raising for historically marginalized groups on FP, RH, GBV and HIV prevention.

5.1.2 Gender
Gender mainstreaming is an integral part of the 6th CP and 15.3 per cent of the five year budget is allocated to gender. Gender-disaggregated data need to be integrated into the RH, PD and gender components for awareness raising, training and advocacy. The CO has been proactive in identifying further areas for support: during 2008 a Gender Based Violence Mapping study was conducted with the NISR to identify gaps in the national response and inform the development of a coordinated response (UNFPA Country Office Annual Report, 2008).

The gender mainstreaming of the DaO process has been facilitated by the establishment of the Gender Task Force, which is responsible for ensuring that gender is mainstreamed in the programme. However, the strong emphasis on gender mainstreaming of the DaO process has tended to mean that there has been less emphasis on gender mainstreaming in the CO at the point of delivery, due to limited resource capacity (MTR 2010). However, capacity for gender mainstreaming remains weak at central and decentralised levels. The district staff we spoke with during fieldwork were unaware that gender was an element of the integrated UNFPA package offered at district level.

5.1.3 Capacity development
Capacity development is central to UNFPA’s work, building organizational and individual capacity. In terms of organizational capacity UNFPA has focused on the development of key policies in RH, PD and gender. UNFPA has supported the development of the Population Policy and the Gender Based Violence Policy. It has strengthened the capacity of Parliament for advocacy on gender and population issues. Institutional capacity to deliver high quality statistical data has been strengthened through support for the introduction of the vital registration system, the IMIS and the setting up of the GMO. The capacity of local staff of has been developed in a number of
key areas in RH, gender and population and development. Examples include training and supervising doctors to perform fistula surgery, NISR staff to carry out the 2012 Census and MIGEPROF and GMO staff to carry out gender impact analysis. The capacity of young people to act as peer mediators has been developed through YFCs, and Gender Clubs and Parliamentarians have been trained to raise the awareness of population issues among religious leaders and other community groups.

5.2 Responsiveness
The One UN model is predicated on the assumption that each UN agency will focus on its area of comparative advantage. UNFPA through its three core components has done this. It has also recognised where it does not have comparative advantage, other UN agencies should take over responsibility. The One UN model has also enabled the development of collaborative programmes with each agency contributing its specialised input. The One Fund has proved to be a successful in mobilising funds and UNFPA has benefitted from this in terms of support for joint initiatives (a priority for the Fund), but also for significant funding for the Census of US$2.6 million.

UNFPA has been responsive to changing needs as they have become evident. UNFPA is also highly valued in Rwanda because of its way of responding to the priorities of IPs, working with them to fund priorities within its mandate.

The 6th CP has been modified to respond to emerging national priorities and needs. During 2008, the CO was requested by government to provide technical and financial assistance for the development of a Road Map for Maternal Mortality consistent with the EDPRS (UNFPA Country Office Annual Report, 2008). UNFPA also supported a needs assessment of Emergency Obstetric Care (EMOC) to enable an appropriate response to needs and as an emergency response. UNFPA provided support for the transportation of clients to EMOC services. Also a condom needs assessment was undertaken to inform a condom programming strategy. A focus on obstetric fistula was included in the formulation of the second Health Sector Strategy Plan (HSSP II) as a result of needs analyses conducted by UNFPA.

In 2011 the need for a M&E Unit in the MINECOFIN was identified and a partnership developed using pooled funding between UNFPA, UNDP and UNICEF. The Unit will strengthen the national integrated M&E system and promote results-based management (UN, 2011).

UNFPA is a member of the Disaster Management Group Task Force and in this capacity is responsible for RH services during disasters. In 2008 UNFPA provided emergency RH Kits for women and girls following the earthquake and in 2010 following the floods. Essential medicines and medical equipment have also been supplied to the One Stop Centres at Kacyiru and Gihundwe hospital. The CO contributed to the training of District Disaster Management Focal Points in sexual and GBV and SRH needs in case of emergency.

5.3. Added Value – Contribution analysis
To assess and measure the impact of aid it is necessary to trace as accurately as possible the strength of the relationship between the amount of aid provided and the results achieved. Three challenges - poor and inadequate data, attribution problems and the difficulty of identifying a reliable counter-factual argument - make this problematic.

Contribution analysis is a tool for M&E and is designed to overcome the problems encountered in assessing the contributions of one donor to results. It seeks to provide plausible evidence that can reduce uncertainty regarding the difference a programme is making to outcomes (Kotvojs and
Shrimpton, 2007). The aim is to use quantitative and qualitative data to provide a ‘plausible association,’ collecting evidence from formal data sets, literature reviews, field visits, FGDs and expert interviews. There are six steps of Contribution Analysis (Mayne, 2001:9)

1. Develop a programme logic (results chain) that details how a programme is intended to work, such that there is a plausible association between programme activities and intended outcome.
2. Existing evidence for the occurrence of the outputs identified in the results chain is collated and the links in the results chain assessed.
3. Alternative explanations for the outcome are assessed.
4. The information collected under 2 and 3 are used to create a story of why it is reasonable to link the programme inputs with the programme outcomes; how credible is the story, do people agree with the story, does the pattern of observed results validate the results chain where are the main weaknesses in the story?
5. Search for additional evidence to improve the performance story.
6. Revise and strengthen the results story.

Contribution analysis should be built into the system from the outset. UNFPA did not include it when planning the 6th CP or its M&E System. This means that we had to develop the programme logic *ex post facto*. Also, with the resources and time available it was not possible to investigate alternative explanations thoroughly or to subject the analysis to independent verification. We were only able to carry out a contribution analysis for the RH component. The first step in doing this was to review the logic of the 6th CP as it relates to the health result in the UNDAF. Table 17 shows the links between the programme logical framework matrix in the *Health Sector Strategic Plan* (MINISANTE, 2009) and the *EDPRS 2008-12*.

**Table 17: Contribution of UNFPA 6th CP to EDPRS health service delivery outcomes**

<table>
<thead>
<tr>
<th>End outcomes</th>
<th>2012 expectations</th>
<th>Alternative explanations</th>
</tr>
</thead>
</table>
| Strengthen reproductive health services and family planning in order to reduce maternal, infant and child mortality, lower fertility and ultimately slow population growth | Performance measures  
MMR 600  
TFR 4.5  
Use Modern Contraception 70%  
Births in Health Facility 75%  
Population H1 95%  
**UNFPA key achievements**  
The *National Strategic Plan for the Reduction of Maternal and Neonatal Mortality and Morbidity*  
- Training for CHWs  
- Community Based Alert System  
- Fistula Care Programme  
- Maternal Death Audits  
- Secondary Family Planning Posts  
- Sensitise population re RH  
- Advocacy re RH  
- Provision of RH commodities | Interviews with key informants at central and the decentralised level indicate that while relatively small in financial terms, the support given has been essential for the achievement of the results. UNFPA support was especially important in the districts as it was often the only cash support they received from donors. |
Having established a logical connection between the 6th CP RH component objectives and these documents, the next stage is to assess the extent to which the 6th CP outputs have resulted in the achievement of the UNDAF Strategic Outcomes and hence to the Health Sector Strategic Plan and EDPRS. The first stage should be done as part of routine M&E on completion of each input. Team members should assess the evidence and alternative explanations for outcomes and update their performance story so that the story logic develops as the programme is delivered. The next stage is to link the UNDAF Outcomes to the Health Sector Strategic Plan and the final stage is to link the outcomes from the Health Sector Strategic Plan to EDPRS. It is that final stage we show here (Tables 18 and 19).

Table 18: Contribution of UNFPA 6th CP to EDPRS Outcome on Communicable Diseases

<table>
<thead>
<tr>
<th>Assess the contribution of the 6th CP to the results achieved:</th>
<th>Alternative explanations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce the incidence of communicable diseases by improving the prevention, care and treatment of malaria, TB and other communicable diseases.</td>
<td>Key informants indicated that UNFPA had played an important role nationally and at a decentralised level and especially in the Female Sex Worker Project, YFCs and the supply of condoms.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Results chain</th>
<th>2012 expectations</th>
<th>Achievements</th>
</tr>
</thead>
<tbody>
<tr>
<td>End outcomes</td>
<td>EDPRS performance measures</td>
<td>• Support for YFCs</td>
</tr>
<tr>
<td></td>
<td>HIV incidence (18-24 years) 0.5</td>
<td>• Female Sex Worker project</td>
</tr>
<tr>
<td></td>
<td>Achievements</td>
<td>• Supply condoms</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Support national condom strategy and programme</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Advocacy re SRH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Sensitisation and training for SRH including for youth, vulnerable groups and faith leaders.</td>
</tr>
</tbody>
</table>

Table 19: Contribution of 6th Country Programme to results achieved

<table>
<thead>
<tr>
<th>Assess the contribution of the 6th CP to the results achieved:</th>
<th>Alternative Explanations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop accessible national training, research and reference facilities of high quality with speciality health care services and state of the art equipment.</td>
<td>Key informants confirmed that UNFPA support for training and supervision for obstetric fistula care in referral hospitals was essential for successful implementation. Key informants also mentioned the importance of UNFPA support for the Maternal Death Audit research. District hospitals noted that the training for medical staff was essential for them to implement the Audit Report findings.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>End outcomes</th>
<th>2012 expectations</th>
<th>Achievements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop accessible national training, research and reference facilities of high quality with speciality health care services and state of the art equipment.</td>
<td>Performance Measures</td>
<td>• Fistula project</td>
</tr>
<tr>
<td></td>
<td>MMR 600</td>
<td>• Maternal Death Audits</td>
</tr>
</tbody>
</table>

For PD and Gender it was not possible to link the outcomes in the UNFPA 6th CP to sector policies and the EDPRS. Whilst there are significant outputs in both components it is much more difficult
to identify tangible outcomes. Much of the input in PD is capacity building at local and central government levels to generate and use quality, gender-disaggregated population data for policy formulation and implementation. The benefits of this for results are not yet evident, although the TFR declined significantly between 2008 and 2010 and trend analysis suggests the EDPRS 2012 target will be achieved. Although it is difficult to attribute any contribution to this from the 6th CP, UNFPA has been working in Rwanda for a long time and undoubtedly support given in the past may have contributed to this.

Gender presents a rather different problem. Rwanda is recognised for the significant progress it has made in gender equality and empowerment. However, there are no specific targets for gender equality or the empowerment of women in the EDPRS Outcome Indicators or Intermediate Indicators apart from those relating to RH. Gender is mainstreamed and the clear intention is to introduce gender-sensitive budgeting and gender impact analysis of all laws, policies practices and procedures. UNFPA is contributing to this at national and decentralised levels, but there is some way to go before all women will experience benefits. UNFPA also plays an important role in the One Stop Centres that provide support to the survivors of GBV and in programmes for vulnerable women to develop skills to generate their own income. Women and men and girls and boys who use these services clearly benefit and the support they receive undoubtedly benefits them, their families and their communities.

As already discussed, good baseline data were not always available to measure the outcomes of the 6th CP, and UNFPA is not the only funder of a programme, so funding other than that provided by UNFPA could have caused or influenced the outcomes. The financial contribution of UNFPA makes up only a tiny proportion of the total funding. Finally, it may not be aid that has influenced the results - there are a range of factors other than aid, internal and external to aid recipient countries - which can and do influence development outcomes.
6. Monitoring and Evaluation System

6.1 Introduction
Monitoring and evaluation is a key element of mutual accountability – the accountability of the Government of Rwanda to its citizens and to UNFPA, and UNFPA’s accountability to the Government of Rwanda, its citizens and to the UN and those who donate funds to the UN. Quality M&E is essential for the CO to carry out adequate management and regular follow-up of the CP.

UNFPA has a sound results-based management system guiding the entire programme cycle. A baseline for indicators was established and outcome indicators identified, in line with EDPRS and MDG targets, together with an indication of where data can be found. Outputs and outcomes are clearly specified. There are regular reviews of progress and progress reports from IPs. An MTR of the programme was carried out in 2010 and the recommendations from it considered and implemented as appropriate.

Following the recommendations of the 5th CP Evaluation a M&E officer was appointed.

6.2 Indicators for monitoring and evaluation
The MTR noted that at the time of the review baseline data were missing for 40 per cent of the CPD indicators. The MTR recommended that the missing baseline data be collected before the end line evaluation. At the time of the ELE, baseline data and or/ targets were still missing for 18.5 per cent of the indicators, for a further 22.2 per cent no data were available to measure progress, leaving 59.5 per cent of indicators (16 out of 27) where it was possible to assess progress against targets (Table 20).

<table>
<thead>
<tr>
<th>Sub-Component</th>
<th>Number of Indicators</th>
<th>Number Progress Measured</th>
<th>Number Waiting for 2010 DHS</th>
<th>Number No Data to Measure Progress</th>
<th>Number No Baseline and/or Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>RH</td>
<td>7</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>HIV</td>
<td>10</td>
<td>6</td>
<td>3</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>PD</td>
<td>6</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Gender</td>
<td>4</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27 (100%)</strong></td>
<td><strong>16 (59.3%)</strong></td>
<td><strong>3 (11.1%)</strong></td>
<td><strong>3 (11.1%)</strong></td>
<td><strong>5 (18.5%)</strong></td>
</tr>
</tbody>
</table>

The MTR also noted that the link between the CPD and the UNFPA outputs and contribution was not clear (pages 58-62). We would concur with this and add that a number of the baseline indicators are problematic. It is not clear, for example, how counting the number of gender sensitive policies implemented, or number of surveys completed, is of value if there is no evidence that the policies have been evaluated for gender impact or that the quality of the surveys has been assessed. In Table 21 we make specific comments on indicators found to be especially problematic. We would suggest that in developing the 7th CP indicators are identified that are SMART (Specific, Measurable, Achievable, Relevant and Time bound), are clearly linked to measuring the outcomes and results, and for which baseline data are available and updated data can be collected to measure progress and outcomes.
Finally, we would note that UNFPA needs to ensure that it uses indicators that measure its specific contribution. Clearly, in a number of instances UNFPA contributes to national change through support to government ministries, sensitisation and advocacy. However, its claim to have made a difference would be much stronger if it also set targets and monitored at district or project level, where relevant. UNFPA’s claim, for example to have contributed to an increase in health facility deliveries would be much stronger if it could demonstrate that it had achieved targets set locally for the DH with which it works and even stronger if it could demonstrate that the improvement there was greater than the country average. To put it in a different way, if, as UNFPA’s analysis suggests, all 30 districts are using disaggregated data for planning, what added value has UNFPA brought to the districts with which it has worked? Would the districts have produced plans using disaggregated data without UNFPA support?

6.3 Conceptual approach to the analysis of the Country Office M&E system

The analysis of the M&E system of a CP comprises five aspects:

- **monitoring inputs and activities** – there is regular monitoring of inputs and activities including field visits, spot checks and reports from IPs; 
- **monitoring outputs and outcomes (results-oriented monitoring)** - monitoring of outputs and outcomes takes place, but this is limited by the availability and quality of data, the quality of the targets, and absence of baseline data and/or targets (Table 21); 
- **monitoring assumptions and risks** - we found no evidence of monitoring assumptions and/or risks, or that a risk analysis had been carried out at the outset of the programme; 
- **integration of evaluation into the M&E system** – evaluation is integrated into the M&E system and includes recommendations of evaluation of the 5th CP and the MTR; 
- **support to national partners in their M&E system including building capacity** - UNFPA during the 6th CP has provided support to national partners in M&E systems and results based planning and all IPs have been trained, but there is a need for further training. The recently agreed project with MINECOFIN for support to build capacity for RBM&E may provide an opportunity further build results-based management capacity into the standardized practices of Ministries and District Councils; 
- **monitoring of risks and assumptions** is an important element of risk management. It enables the identification of potential risks and the development of avoidance strategies. However, we could find no evidence that UNFPA undertakes risk analysis and risk reviews as an element of its planning cycle.

6.4 Monitoring and evaluation system in the Country Office

The inter-agency M&E Task Force provides technical guidance and support to the planning, monitoring and evaluation process. The M&E Officer of UNFPA is one of the two Database Administrators. The Task Force ensures that CAPs are of high quality in terms of RBM&E and SMART principles and are fully aligned to the UNDAF results framework. It also provides guidelines for the assessment of joint proposals and helps review them. In 2010, a joint initiative was developed to support national planning and monitoring and evaluation capabilities. There is a One Programme Monitor (a web based inter-agency monitoring and reporting system) introduced in 2010 which provides a powerful tool for budgetary and spending tracking analysis, planning and implementation trend and performance analysis (UN Rwanda, 2011). The Resident Coordinator allocates the One Fund to agencies on the basis of their performance as recorded in the One Programme Monitor.
Table 21: Comments on data issues related to specific indicators

<table>
<thead>
<tr>
<th>CPD indicator</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of government budget allocated to health</td>
<td>UNFPA has a target of 15 per cent of budget for health as recommended by the Abuja Declaration. This seems unrealistic as the Government’s target in EDPRS is 9.2%. Also it is not clear how the budget allocated is an indicator of efficiency and effectiveness of the health care system. (^{48})</td>
</tr>
<tr>
<td>Percentage of health facilities providing a complete and integrated service package including maternal, adolescent and child health services</td>
<td>There is no target set for this indicator. We have not been able to verify the baseline data and the number providing a full package for 2010. We have used the data as in the UNFPA M&amp;E reports.</td>
</tr>
<tr>
<td>Percentage of obstetric gynaecological admissions for post-operative care for abortion</td>
<td>No baseline or target has been set. We were not able to verify the 3% figure for 2010 in the UNFPA M&amp;E reports. It is unlikely that most women who abort will seek medical care. Abortion remains illegal and access to modern contraception (other than condoms) is difficult for legal and cultural reasons for women under 21 years and unmarried women suggesting that this might not be an appropriate indicator. There are alternatives to measure the unmet need for contraception amongst couples.</td>
</tr>
<tr>
<td>Percentage of faith-based organizations promoting RH and family planning at community level</td>
<td>UNFPA measures this by the number of national religious leaders who agree not to oppose family planning. However, this says nothing about what religious leaders say at a community level and the effects of the religious leaders’ agreement with Government not to oppose contraception in 2007 (National AIDS Control Commission 2007). Informants told us during the evaluation that some religious leaders did oppose contraception and encouraged married couples not to use contraception. At a facilitated debate on population management held earlier this year delegates indicated that religion remained a barrier to the use of modern family planning methods (Abbott 2011). Furthermore, it is not clear how the data for this indicator would be collected. We suggest that given the base line is 0 per cent and the target for 2012 is 10 per cent the target was indeed intended to measure the percentage of religious leaders promoting contraception. This remains at 0 per cent as far as we can ascertain. However, we are not aware of any data being collected to measure this.</td>
</tr>
<tr>
<td>No. of surveys, studies, assessments and reports produced for policies and planning by the national statistical system.</td>
<td>The target for this is unrealistic. NISR to a large extent plans their work so it would be possible to ascertain what is planned, but it is not clear what the target measures. NISR has significant support from consultants and it is unlikely that surveys etc. would not meet its targets.</td>
</tr>
<tr>
<td>No. of District Plans based on disaggregated data</td>
<td>The 100% figure comes from a review of plans by UNFPA CO. It was a review of the use of data and not the quality of data used.</td>
</tr>
<tr>
<td>No. of districts with Civil Registration systems established and functioning</td>
<td>We have not been able to verify the figure in the UNFPA M&amp;E reports, but the districts visited all reported struggling to set up a Vital Registration System. Districts are being supported to establish systems over the period of the 6th CP so they still have time to become operational.</td>
</tr>
<tr>
<td>No. of published documents and studies based on data for RH, PD and gender</td>
<td>The target for this is 10 and the UNFPA M&amp;E report gives a figure of 6 for 2008. We were unable to determine what the criteria is for inclusion in the total, or what 6 documents the figure in the report refers to.</td>
</tr>
</tbody>
</table>

\(^{48}\) UNFPA CO has argued that this was meant to be an indicator of total Government spending on health. This is not what the indicator suggests and shows the necessity of ensuring that indicators are clearly specified. Data produced by the Ministry of Health suggests that total Government spending on health is 16.05% of total government spending. This figure has not been validated by the MINECOFIN.
<table>
<thead>
<tr>
<th><strong>CPD indicator</strong></th>
<th><strong>Comment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Districts with local disaggregated databases with an emphasis on young people, women and people living with disabilities used for poverty mapping and planning.</td>
<td>We have not been able to find any reliable information on the number of districts with databases with disaggregated data. However, the RALGA 2010 report indicates that lack of data is a major constraint for districts. The informants we spoke to in the districts were still setting up their data bases.</td>
</tr>
<tr>
<td>Percentage of educational institutions using an MIS</td>
<td>The EMIS does not yet seem to be operational. It is unclear why this is a UNFPA target as they are not supporting the EMIS project centrally or locally.</td>
</tr>
<tr>
<td>Number of out-of-school youth that attend YFCs</td>
<td>The figure for 2012 seems unrealistic as YFCs do not collect information on whether those who attend are in-or-out of school.</td>
</tr>
<tr>
<td>Health indicators generally</td>
<td>These are generally based on the DHS which is carried out every five years. The most recent in Rwanda being the 2010 survey. An interim survey was carried out in 2007. The results of the 2010 survey have not yet been released so for some RH indicators we have no data (or unreliable data).</td>
</tr>
<tr>
<td>No. of public and private institutions applying the 30 per cent quota for women</td>
<td>It is not clear which institutions are included, or the status of the quota. The Constitution requires that 30 per cent of seats in the House of Representatives are reserved for women and Election Law requires the same for decentralised elected bodies. It is an unrealistic target given the skills shortages in Rwanda with women, on average, being less well qualified than men.</td>
</tr>
<tr>
<td>No. of institutions with transparent non-discriminatory promotion systems</td>
<td>It is unclear which institutions are included. Unless there is a clear definition of institutions to be included it is not possible to measure progress. Also it is not clear how it is determined that an institution has a transparent non-discriminatory promotion system.</td>
</tr>
<tr>
<td>No. of Development Partners with gender focal points trained and equipped with gender planning tools.</td>
<td>We took this to be UNFPA’s DPs, but could find no evidence that they systematically collect data on this. Given that the number of DPs may change across the course of a five year programme an increased number may not be indicative of an increase if the number of DPs has also increased. The target is not SMART – it is the implementation of gender planning that should be measured.</td>
</tr>
<tr>
<td>No. of gender sensitive policies and programmes in sexual and RH and in population and development.</td>
<td>The indicator seems to be at odds with the target. The latter makes reference to four sectors, not policies. It is unclear how policies are to be assessed for being gender sensitive.</td>
</tr>
</tbody>
</table>
7. Results and Efficiency

Assess the extent to which the planned results have been achieved in a cost effective and efficient manner using results-based management with gender mainstreaming being used in the design of the programme.

7.1 Introduction
For all the areas of intervention there is evidence of progress, as Chapters 2, 4 and 5 show, even when a lack of data prevents us from measuring progress using UNFPA indicators. We cannot, however, demonstrate that the UNFPA contribution represents the most efficient use of resources or that they could not have been achieved more efficiently in other ways.

The efficient use of resources is important to ensure that the aid expended has the maximum social benefits, and it is an important element of accountability. Transformation efficiency is the extent to which money time and/or effort has been well used for its intended purpose. The Development Co-operation Directorate of OECD suggests that aid should use the least costly resources possible to achieve the desired results. This requires considering if the activities were cost-efficient, if they were achieved on time and if the programme was implemented in the most efficient way compared with alternatives. It is also important to understand the efficiency of an intervention in terms of selecting interventions for continued funding and/or scaling up. However, efficiency is not the only factor to be taken into account; other factors such as the acceptability of an intervention to beneficiaries, and sustainability, may be relevant.

It is beyond the scope of this evaluation to compare the efficiency of the 6th CP with alternatives, and with the data available to us it was not possible to carry out a rigorous efficiency analysis (Palenberg, 2011). Adequate data on expenditure were available, but not quality data on which to base a judgment of the extent to which results had been achieved efficiently. The M&E Framework was found to be inadequate in three main respects: i. unrealistic and/or poorly formulated targets were set; ii. data to measure progress are not yet available for a number of targets; and iii. in a number of cases baseline values and/or targets were not set.

In terms of disbursement of funds, delays in transferring funds are referred to in the data file and this was also mentioned by IPs interviewed. The late submission of AWPs by IPs was also mentioned by UNFPA as contributing to delays in releasing the next tranche of funding. Although core funding was secure, there was no certainty that ‘still to be mobilised’ funds would be forthcoming, making the efficient allocation of resources problematic.

A number of the Government key informants stressed the importance of aid being spent through Government agencies, pointing to the inefficiency of parallel IPs. The vast majority of the financial assistance that UNFPA disburses is to Government agencies.

7.2 Measuring the efficiency of the 6th Country Programme
To measure efficiency we need information on costs and the outcomes that can be attributed to the intervention. Figure 25 in Chapter 3 shows the budget allocated to date and the amount disbursed. We discuss the extent to which progress has been made and the extent to which the outcomes for
each component have been achieved, based on the available evidence. We then estimate the percentage of the results achieved to date and use this as the basis for calculating efficiency. The findings are indicative and are shown for each component.

In Table 22 we look at progress to date using the targets in the M&E Framework and calculate the proportion of expected results achieved by the end of 2010, three years into the programme. We use trend analysis wherever possible to estimate the potential for achieving the expected results by the end of 2012. We were not able to do this analysis for the Gender component because available data are insufficient.

The scores are based on the extent to which the outcomes and outputs as measured by the key performance indicators are likely to be achieved by 2012. Thus a score of a 100% indicates that the target is on track to be met. Lower scores indicate the proportion of the outcome/output achieved as compared with what would be necessary at this stage if it was on track. Where we have three data points we have used trend analysis.

The RH component has made good progress - not unexpectedly, because Rwanda has improved on its RH indicators over the last 10 years. The score of 60/80/100 per cent is acceptable. The score depends on the interpretation of the meaning of the targets with the 60 per cent figure assuming that the target for health spending related to the allocation of the budget for health as reported in the Finance Bill and the EDPRS M&E, or the total allocated to health. The score for local religious leaders’ promoting family planning depends on if this was meant to mean national leaders not opposing family planning.49 The score of 60 assumes neither of these targets was met, the score of 80 that one target was met and that of 100 that both targets were met.

The score for the HIV component is disappointing at 43.4 per cent. The indicators for service delivery (YFCs and condom distribution) are well on track to be achieved (Figure 19 above). However, whilst there is some evidence of increased use of HIV prevention methods by young people the increase is less than 50 per cent of that required to be on track to achieve the 2012 target (Figures 16 and 17 above). The numbers of young women using HIV prevention measures has increased more rapidly than for young men, and when we consider adult men and women the proportion of men who take preventative action declined in 2010 compared to 2005. There is no evidence of any decline in PMTCT; following a dramatic fall between 2005 and 2008 the rate of PMTCT has remained static since (Figure 11 above). Undoubtedly when the data becomes available we would expect that the target for knowledge about where to obtain condoms will be on track. However, this is may be cancelled out by slow progress towards the target for the proportion of the population knowing their HIV status. The proportion of the adult population using VCT services is estimated to be insufficient for the target to be achieved.

The score for Population and Development is 54.7 per cent. Overall UNFPA is likely to achieve the programme of work it has with the NISR and it has already completed work with MINECOFIN on the revised Population Policy. However, it seems to have overestimated what could be achieved at the decentralised level in terms of building capacity to collect and use quality statistical data. Good progress has been made in using disaggregated data in District Development Plans and in the use of data in documents, but less progress made in developing the Vital Registration System. The districts we visited were struggling with establishing systems and expressed a significant need for capacity building. They have had their awareness of the need for data raised; they now need capacity building in to how to collect reliable data for use in planning.

49 However, as noted above if it is taken to mean the latter the target had already been achieved before the 6th CP was introduced.
The target for the number of NISR surveys to be undertaken was unrealistic and not likely to be achieved. The EMIS is not yet operational and we can find no evidence that UNFPA has contributed to its development during the course of the 6th CP.

Table 22: Results of the 6th Country Programme

<table>
<thead>
<tr>
<th>Result/Outcomes in M&amp;E Framework</th>
<th>Indicators</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>RH</td>
<td>% of government budget allocated to health, there has been no increase.</td>
<td>0%/100%</td>
</tr>
<tr>
<td></td>
<td>% Assisted Deliveries is on track to be achieved</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Integrated Health Package – no target</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Post-abortion care – no target</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% Umudugudu with 2 trained CHWs</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>% FBOs promoting RH/FP</td>
<td>0%/100%</td>
</tr>
<tr>
<td></td>
<td>Number of health facilities with a youth friendly service</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>60%/80%/100%</strong></td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Outcome Indicators</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% At-risk female &amp; male aged 18-24 use condom for HIV prevention - male and female off track (Figures 16 &amp; 17)</td>
<td>44.3%</td>
</tr>
<tr>
<td></td>
<td>Mother-to-child-transmission off track.</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>% At-risk population adopted HIV prevention methods – male and female off track (M-27%, F36.6%)</td>
<td>9.6%</td>
</tr>
<tr>
<td></td>
<td>Number of YFCs – on track</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>% 15-24 year olds know where to get condoms – no data</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of condoms distributed</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>43.4%</strong></td>
</tr>
<tr>
<td>Population and Development</td>
<td>Number of surveys etc. by NISR off track</td>
<td>28%</td>
</tr>
<tr>
<td></td>
<td>District plans based disaggregated data</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Documents based on RH, population, and development and gender data looks on track</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Districts functioning Civic Registration System</td>
<td>45.9%</td>
</tr>
<tr>
<td></td>
<td>Districts with disaggregated data bases</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>EMIS Operational</td>
<td>54.7</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>54.7</strong></td>
</tr>
</tbody>
</table>

The global cost-effectiveness for the 6th CP is 1.58/1.45/1.25, which suggests a significant gap between achievements and costs. Taking the COs interpretation of the targets, this gap is significant for all components of the programme apart from RH. Using this analysis, the 6th CP has not been efficient to date. Five points should be kept in mind when considering this finding, however. First, there is still more than a year of the programme to run and progress towards achieving outputs and outcomes may be better than our analysis suggests. Secondly, a number of the indicators were poorly formulated; had other, more appropriate ones been used the outcome may have been somewhat different. This would seem to be the case for RH component. Thirdly, we are using output and outcome indicators and not activities – we are measuring results against targets. This is always challenging, and the achievement of 75 per cent of targets would generally be seen as satisfactory. Fourthly, the targets were unrealistic, based on the level of funding available. Finally and most importantly, most of the indicators are

50 Score is calculated only including data for which a baseline and target where set or where the 2012 target has been achieved.
51 The first figure is for our reading of the target, the second for the COs interpretation.
52 The first figure is for our reading of the target, the second for the COs interpretation.
53 The first figure is based on our reading of the targets, the second the COs interpretation.
global, but UNFPA only makes a relatively small contribution to activities that might have an impact on the indicators.

Table 23: Cost effectiveness ratio by component

<table>
<thead>
<tr>
<th>Programme and Components</th>
<th>Cost (% of budget spent)</th>
<th>Effectiveness (% of results achieved)</th>
<th>Cost-effectiveness ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Component</td>
<td>82.6%</td>
<td>52.4%/57%/66%</td>
<td>1.58^{±}/1.45/1.25</td>
</tr>
<tr>
<td>RH</td>
<td>94%</td>
<td>60%/80%/100%</td>
<td>1.57/1.18/0.94</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>70.7%</td>
<td>43.4%</td>
<td>1.62</td>
</tr>
<tr>
<td>Population and Development</td>
<td>82.5%</td>
<td>54.7%</td>
<td>1.5</td>
</tr>
</tbody>
</table>

To a large extent this analysis confirms the findings from the other Chapters of this report. UNFPA is undoubtedly making a contribution to the realisation of development outcomes in RH, HIV/AIDS and Population and Development. It contributes technical support at national and decentralised levels in advocacy, awareness raising, capacity building, education and service delivery. However, with the exception of RH outputs and outcomes, tangible results have not been achieved to date. For HIV, the findings suggest that while the population are aware of HIV and understand how it is transmitted and what preventive measures need to be taken, the behaviour of those who have unsafe sex has not changed as rapidly as anticipated. In PD some of the indicators are problematic and UNFPA may have underestimated the time necessary to raise awareness at the District level and to get a vital registration system installed and up and running.

^{±} The first figure in this column is based on our reading of the indicator and the target data and the second based on UNFPAs.
8. Conclusions and Recommendations

8.1 Main conclusions

8.1.1 Strategic Level

**Conclusion 1:** UNFPA support to Rwanda is well aligned with the Fund’s strategic plan, including support for disadvantaged and vulnerable groups (such as, youth, and female sex workers). The five districts in which UNFPA works were selected because of their relatively poor RH performance and higher rates of HIV infection. They also border on the Democratic Republic of Congo, and support is provided for internally displaced persons. Capacity development is also well integrated across all three components of the programme.

**Conclusion 2:** Rwanda is a pilot country for DaO and the evaluation of the pilot was generally positive. UNFPA has been able to focus on areas where it has a comparative strength and work with other UN agencies to deliver joint projects. The Joint Gender Project seems to be working well, but the Youth one less so. UNFPA benefitted from the One Fund and has had significant funding to provide technical support to NISR for the 2012 Census.

**Conclusion 3:** UNFPA generally adheres to the Paris Declaration principles of ownership, alignment, harmonization, management for development results and mutual accountability in developing and delivering its programme. UNFPA supports the government priorities in RH, PD and gender and works with IPs to implement their priorities. Funding is transferred to the IPs government reporting systems are used to monitor disbursement. There is a strong emphasis on capacity building and established mechanisms for mutual accountability. Communication and reporting between IPs including MINECOFIN and UNFPA remains problematic. UNFPA funding is reported to the DAD, but not yet included in the Finance Bill.

**Conclusion 4:** the 6th CP is aligned with Rwanda’s development goals as articulated in Vision 2020 and EDPRS and UNFPA has been responsive to the needs of IPs. The UNFPA programme is clearly aligned with the country’s development priorities in the areas of SRH, Population Policy, the need for quality statistical data including gender-disaggregated data to inform policy formulation and implementation, gender and youth. There is a clear alignment with government priorities and UNFPA funds IPs plans, agreeing with them what it will support according to its mandate.

**Conclusion 5:** The focus of intervention remains a problem even though the number districts supported has been reduced from 14 to five following the MTR. The stakeholders were strongly of the view that UNFPA was insufficiently focused in its areas of intervention and that this adversely affected impact. The need to become even more focused to ensure maximum impact was expressed strongly by key informants. It was clear from the district-level interviews that the support UNFPA was able to provide was inadequate to meet need. Our impression was that UNFPA is providing relatively small amounts of support to a large number of activities.
Conclusion 6: Contribution analysis demonstrates that the aid UNFPA disburses in Rwanda makes a contribution to the achievement of the Rwanda’s development goals. The analysis suggests that the 6th CP has made a contribution especially in the reduction of maternal mortality, increased use of modern contraception and increased deliveries in health centres. Three of the activities for which UNFPA provides technical and financial support were seen to be especially important by key informants - the former Sex Worker Project, the support for YFCs and the support for One Stop Centres for survivors of GBV.

Conclusion 7: Sustainability remains a challenge in a country that depends on aid for half its budget and where there is a shortage of skilled and competent labour. The high turnover of employees in IPs means that technical support for capacity building does not always build the capacity of the organization in the long term. There is strong evidence that FP and maternal health care have strong local ownership and that the reform programme is driven by the Government. There have been significant improvements in FP and maternal health care outcomes over the last five years with support from development partners. Technical support and commodity provision are still needed to develop a sustainable national programme.

8.1.2 Programme level

Conclusion 8: The UNFPA programme provides support to the Ministry of Health for the development and implementation of RH policies and strategies, to districts for community RH and to the CLNS for HIV policy development and implementation. UNFPA supports advocacy, awareness-raising, education on SRH, policy development and implementation, service delivery and the supply of SRH commodities. UNFPA has notably supported the development of the health sector strategic plan, research into maternal mortality and the introduction of activities to reduce maternal mortality and provide obstetric fistula repair. It has supported awareness-raising activities and advocacy related to SRH for the community in general and especially for vulnerable groups. UNFPA has assisted with the establishment of secondary family planning posts near Catholic health centres and sensitised religious leaders on SRH. A programme for former sex workers has been developed and implemented. A basic package for YFHS has been developed as well as support for the operation of three YFCs and two clinics operated by ARBEF. The main shortcomings in the RH component are the lack of integrated SRH services (including FP, HIV and STI prevention and treatment services) and cultural barriers to FP.

Conclusion 9: The PD component provides support to MINECOFIN for population issues and for M&E. UNFPA provides funds and equipment to NISR for the collection and dissemination of statistical data on population and to the districts for the use of statistical data in planning and for the vital registration programme. It also invests in training and skills development at NISR and in the districts and in improving statistical production and data accessibility. UNFPA provides support to the MIJESPOC for developing YFCs. The support to NISR and MIJESPOC was effective in producing planned results. Support to the districts is also enabling them to understand the need for quality disaggregated data and for Vital Registration. However, the districts still need significant support, technical and equipment to develop fully functioning systems for data collection, analysis and use for planning.
Conclusion 10: The gender component consisted of technical support to the MIGEPROF, the Gender Monitoring Office and women Parliamentarians and, working with other UN agencies, the One Stop Centres and the Agaseke Project in Kigali City. Gender is also cross-cutting. The Female Sex worker project is part of the RH programme and the PD component emphasises the collection and use of gender disaggregated statistics. It was difficult to evaluate the impact of this component. However, there remains a significant need for technical support for gender mainstreaming and the collection and use of gender-disaggregated data nationally and at decentralised levels. The One Stop Centres are important given the extent of GBV in Rwanda, as are the projects to enable vulnerable women to develop the skills for income generating work and thereby provide them with a sustainable livelihood.

8.1.3 Transversal Aspects

Conclusion 11: The short time span between the MTR and the End of Line Evaluation raises questions. Timing of the End of Line Evaluation a year ahead of the end of the programme adversely affects the scope of the evaluation. Although it is acknowledged that the ELE has to be conducted during the penultimate year of the CP so that the results can feed into the design of the new programme (June 2010 DP/2010/34 Executive Board Decision). Although the objectives of a MTR and an ELE are not the same, both involve an assessment of the programme’s progress in terms of the activities and the degree of achievement of outputs. However, many of the data are the same and the short time span does not allow the ELE to clearly add value to the findings and conclusions of the MTR, or to evaluate any adjustments made to the programme as an outcome of the MLR. Furthermore, it adds considerable transaction costs to UNFPAs partners, who have met with two sets of evaluators assessing similar issues. Data to measure progress are problematic and even when available they do not easily permit trend analysis, for which at least three data points are required. Furthermore, in the case of Rwanda the evaluation took place about a month before the Government’s annual review of EDPRS was due to be published and about six months before the findings of the 2010/11 Household Survey were due. Preliminary findings from the 2010 DHS were made available to the review team while they were carrying out the evaluation but the full findings will not be available until early 2012.

8.1.4 Country Office M&E System

Conclusion 12: The CO has a robust M&E System in place and a M&E Officer is in post. M&E activities are carried out and inform the implementation of the programme. IPs have been trained in Results Based M&E, although there is clearly a need for further capacity building. However, the indicators for measuring impact are not routinely well selected and/or specified. Not all of them are clear measures of UNFPA work; baseline data are not available for all of them, and for others recent data to measure progress are not available. Furthermore, robust methods that enable the attribution of outcomes to specific inputs are not always appropriate for the activities that UNFPA funds. This present challenges in having a robust set of SMART targets with baseline data and in having quality data collected at regular intervals. There is a lack of evidence of evaluation of specific projects that could measure the impact of UNFPA’s work - for example the former sex worker project, the YFCs and the health centres UNFPA supports. There was, however, a good evaluation of the Maternal Death Audit Project.
8.1.5 Efficiency

**Conclusion 13:** Difficulties were experienced in measuring outputs and outcomes, due to the lack of specified baselines and/or targets in some cases. The absence of recent data to measure progress in some areas, made it difficult to carry out a robust efficiency analysis. This was compounded by what seemed to be over-ambitious targets. To the extent we were able to carry out an analysis the 6CP did not seem efficient, with the possible exception of RH.

8.2: Recommendations to UNFPA for Priorities for the 7th Country Programme

Our recommendations focus on priorities for the 7th CP to UNFPA based on the strengths and weaknesses encountered in the implementation of the 6th CP. The 7th CP will start in June 2013 and be aligned with the Government’s financial year and the implementation of EDPRS 2. The programme will have two sub-components, RH and Population and Development. It has been agreed as part of the government’s aid agenda and UN DaO that gender will be mainstreamed across all sectors, so there will be no separate UNFPA gender component.

UNFPA should continue to provide technical assistance within the spirit of the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action. Whilst becoming even more focused it should nevertheless remain responsive to emergencies and emerging government priorities and continue to focus on the weakest and most vulnerable. It should also consider how it can further develop South-South cooperation into its programme.

**Priority 1:** Align UNFPA 7th Country Programme with Rwanda’s development priorities and needs as set out in EDPRS 2 and District Development Plans.

The government is reviewing EDPRS 2008-12 and EDPRS 2 will be implemented from June 2013. UNFPA should ensure that it aligns the 7th CP with the priorities identified in EDPRS 2. UNFPA should also continue to work with IPs to identify priorities in line with UNFPA’s mandate. It should also use the findings from the 2010 DHS when they are available to redefine priorities and redirect funds.

**Priority 2:** Focus the interventions so that UNFPA’s investment makes a difference and there is real impact.

UNFPA should focus interventions to demonstrate real impact, rather than to engage in a large number of activities. UNFPA should prioritise a small number of projects and focus interventions where it has a comparative advantage at both central and decentralised levels. The number of activities engaged in should be limited and targeted support provided where it can make a difference. Consideration should be given to further reducing the number of districts worked in as all the districts expressed concern about the adequacy of funding.

**Priority 3a:** Focus on young people to change their fertility behaviours through delayed first sex, reduction of pregnancy amongst adolescent girls, preference for a smaller family size, and continued access to a range of male and female contraceptive methods.

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55 The support of sensitisation, training, policy development and implementation and service delivery lies with both the Health Team and the Population and Development Team. The Population and Development Team support the Ministry of Youth, Sports and Culture and the districts with Youth Friendly Centres, whilst the Reproductive Health Team supports the Ministry of Health and the district hospitals with Youth Friendly Health Services. The Population and Development Team should be responsible for awareness raising and education and training for young people.
**Priority 3b:** Focus on the prevention of HIV and sexually transmitted infections amongst male and female youth in the five districts.

**Priority 3c:** Integrate sexual and RH services for young people in Youth Friendly Health Services (YFHS), develop national norms and standards for YFHS and build capacity of staff to offer quality services appropriate to the needs of young people.

The evidence shows that youth in Rwanda (aged 15 to 24 years) have specific needs for the prevention of unintended pregnancy, HIV and STIs. They need increased access to sexual and RH services based on their needs. These services should be integrated and include contraception (for married and unmarried youth), counselling, HIV (VCT) and STI testing and treatment, and management of adolescent pregnancy. These services could be at stand-alone clinics, or on special days at the health centre or health posts. Irrespective of how these YFHS are organized logistically, there need to be nationally agreed norms and standards of care developed in conjunction with young people and health service providers. Alongside this, YFHS staff will need to be trained in delivering quality YFHS and a monitoring system established to assess the appropriateness and acceptability of the services for youth.

It is also important to sensitize CHWs to the special needs of youth and adopt a non-judgmental approach. Emphasis should be placed on educational programmes for youth as part of the YFCS to promote the desired SRH behaviour. Youth Friendly Centres should in addition to offering advice on SRH, provide youth with skills for income generation.

**Priority 4:** Continue to provide support for the Sex Worker Project nationally and in Rubavu and Kigali following a review of the work to date and develop a strategy for scale-up of services provided. Focus in the future on the regular partners and male clients of sex workers and promote condom use amongst them.

Key informants highlighted the importance of the work UNFPA were doing in supporting former sex workers both by supporting the development of policy and the support for the project in Rubavu. This work supports efforts to reduce the spread of HIV and to enable vulnerable women to gain the skills for sustainable income generating activities.

**Priority 5:** Continue to provide support for the obstetric fistula care project and develop a strategy for scale-up of services to ensure that all women who need fistula repair are able to receive it.

Significant progress has been made in reducing the MMR and there is strong government commitment to further reduction. It therefore seems appropriate for UNFPA to focus attention on supporting efforts for interventions to support women with obstetric fistula and this also needs to be linked with interventions to increase the age of marriage and first pregnancy, and to reduce the number of children that women have.

**Priority 6:** Continue to support the One-stop shop Centres in Kigali and in Gihundwe Hospital and scale-up GBV services so they are available throughout Rwanda and build capacity of staff as required.
The high incidence of GBV and the strong support of the government for work in this area indicate that UNFPA should continue its support for One Stop Centres.

Examples of good practice in the Sex Worker Project, the Fistula Prevention and Treatment Project and One-stop shop Centres for GBV should be built upon. A survey of the need for such services should be conducted and services scaled-up accordingly with staff capacity built and standards of care, supervision and monitoring systems developed.

**Priority 7**: Continue to advocate and raise awareness for RH and population and development, paying specific attention to the unmet need for family planning and ensure that staff capacity is build and commodities are available to support these services from a range of public and private sector providers.

The promotion of public private partnerships (PPP) for the Rwanda Family Planning Programme needs to be intensified to ensure the sustainability of RH commodities (condoms and contraceptive methods). This should be done through the: i. creation of a Coordination Committee for PPP in family planning, sexual and RH; ii. development of a PPP strategy which includes measures to target public sector resources more effectively and expand social franchising of RH commodities and services.

**Priority 8**: Continue work with the districts to further develop capacity for the collection and use of statistical data in planning and establish and operationalize the vital registration system.

Building national capacity in monitoring and evaluation and the provision of specific technical support to the national vital registration system and the collection of disaggregated data for RH, population and development should be continued.

**Priority 9**: Continue to support the National Institute of Statistics, Rwanda and the Gender Monitoring Office to collect and analyse population data to inform policy development and implementation with an emphasis on the collection of gender disaggregated data.

The government is committed to promoting gender equality and the lack of gender disaggregated data to inform policy formulation, implementation and M&E

**Priority 10**: Strengthen the monitoring and evaluation system through the identification of appropriate indicators that are consistent with UN global indicators. Continue to strengthen UNFPA internal capacity and the capacity of its implementing partners in monitoring and reporting results, including efficiency and Contribution Analysis.

There is need for improved indicators in the 7th CP and UNDAF that are consistent with UN global indicators, for example, the UN General Assembly Special Session (UNGASS) Core Indicators on HIV. The design of the programme should identify alternative explanations for anticipated changes and incorporate contributory analysis into M&E activities. Support should be provided to projects for the identification of appropriate indicators to measure progress to achieve outputs and outcomes and use these as an integral element of M&E.
The cost effectiveness analysis and contributory analysis should be built into the UNFPA M&E Framework from the outset. A risk analysis of the 7th CP should be carried out when it is drafted and strategies developed for overcoming the risks identified. A theory of change that enables the identification of the preconditions for achieving outputs and outcomes, especially as these relate to behaviour change, should also be developed.

8.3 Recommendations to the Government, Implementation Partners and the United Nations

11. The government should facilitate the process of UNFPA support to government priorities in order to add value to the implementation of EDPRS2.
12. Districts should clearly identify priorities for funding with UNFPA to enable them to fully develop and implement the systems for collecting and using statistical data including the vital registration system.
13. The Population Desk in the MINECOFIN in collaboration with UNFPA should identify the technical support required from UNFPA to implement the Population Policy once Cabinet approval has been granted.
14. The National Institute of Statistics, Rwanda should appraise UNFPA of the technical support required under the 7th CP to improve the vital registration system and use of disaggregated data for planning and monitoring.
15. CNLS should agree with UNFPA how the former sex worker programme and HIV interventions with most at-risk young people can be taken forward and scaled up and identify areas where UNFPA technical support is required.
16. The Ministry of Health should develop an implementation plan for Youth Friendly Health Services and identify areas where UNFPA technical support is required.
17. The Ministry of Health should develop an implementation plan for scaling up the Obstetric Fistula programme and identify areas where UNFPA technical support is required.
18. The Ministry of Health should develop an implementation plan for scaling up GBV services so they are available throughout Rwanda and and identify areas where UNFPA technical support is required.
19. The UN Agencies in Rwanda should continue to identify areas where they can work together to support to the government of Rwanda in reproductive health and population and development, including taking forward areas where there is existing collaboration.
20. The UN should consider how it can further ensure collaborative working between the various agencies to reduce transaction costs especially in the health sector.
References


Index of Documents from UNFPA Consulted

FOLDER NAME - DOCUMENTS FOR ENDLINE EVALUATION
FOLDER NAME: AWPS
FOLDER NAME: 2011 FINAL AWP 13 DEC
File name: AWP2011_MINSANTE_13-12-2010

File name: AWP2011_RALGA FINAL

File name: AWP2011 MINECOFIN & NISR FINAL

File name: AWP 2011 RPRPD FINAL
File name: FFRP ANNUAL WORK PLAN 2011
File name: FINAL CNLS – UNFPA 2011 AWP
File name: Financial overview AWP 2011
File name: GMO ANNUAL WORKPLAN 2011
File name: MIGEPROF ANNUAL WORK PLAN 2011-1
FOLDER NAME - AWPs and LOU 2009
Folder name: Gender
AWP 2009 gender (excel file)
Sheet 1 named AWP 2009 (Annual work plan 2009)
Sheet 2 named budget sheet (Budget sheet Annual Work plan 2009 for MIGEPROF)
Sheet 2 named ONE FUND (Annual Work plan 2009 for MIGEPROF; ONE FUND BUDGET SHEET RWA6G38A Sub Act and Key Act)
File name: LoU AWP 2009 – MIGEPROF FINAL 20 01 09;
Letter of Understanding between MIGEPROF and UNFPA; For the implementation of the UNFPA-funded Annual Work Plans 2009: “Women’s empowerment, gender equality and access to RH services”. Approved as part of the 2008-2012 CP.
Folder name: HIV
File name: AWP HIV Cover
UNFPA Annual work plan 2009 country Rwanda
File name: AWP RH CNLS
Excel sheet; Draft AWP 2009 HIV
File name: LoU AWP 2009 –CNLS
Letter of Understanding between CNLS and UNFPA; For the implementation of the UNFPA-funded Annual Work Plans 2009. “Quality HIV Prevention services” Approved as part of the 2008-2012 CP.

Folder Name: P & D
File name: AWP 2009 MINECOFIN
File name: AWP 2009 RPRPD-FFRP
File name: LoU AWP 2009 MINECOFIN final
Letter of Understanding between CNLS and UNFPA; For the implementation of the UNFPA-funded Annual Work Plans 2009. “Quality HIV Prevention services” Approved as part of the 2008-2012 CP.
Folder name: RH
File name: 190109 cover MOH_AWP2009Final
Document Title: UNFPA Annual Work Plan 2009, Rwanda; dated 20 January 2009
File name: AWP RHR MoH
Excel sheet name AWP09: Title UNFPA Annual Work plan: Improving Health System and Access to Quality Comprehensive RHR Services including FP and EmONC
File name: LoU AWP 2009-MOH_FINAL
Letter of Understanding between the Government of Rwanda and UNFPA; For the implementation of the UNFPA-funded Annual Work Plans 2009. “Improving health system and access to quality comprehensive RHR services including FP and EmONC”” Approved as part of the 2008-2012 CP.
Folder -CAPS
Folder NAME- CAP2009
Folder NAME: CAP Governance 2009
File name: AWP 2009 RPRPD-FFRP
File name: AWP 2009 MINECOFIN
File name: CAP_2009_Governance _UNFPA (1)
Excel sheet name UNFPA input Gov TG: No title
File name (Excel): CAP Governance 2009
File name: Minutes of the meeting of 20 february09
Document title: Minutes of the meeting of 20 February 2009; Technical Group on CAP health 2009 UNICEF – Dr Friday’s office
File name: ToR Subgroup CAP indicators
Document title: Terms of Reference; Technical Group on CAP health 2009
File name: UMRRS Form1 2009 1 All results.xls. ETG 16.12.08
Excel sheet name Form 1: No title
File name: UMRRS Form1 2009 Gov result
Excel sheet name Form 1: No title
File name: UMRRS Form2_2008_3_ Education_UNFPA
Excel sheet name Form2: No title

Folder NAME: CAPS 2010 FINAL
File name: CAP 2010_Education TG
1 Excel sheet name: EDUCATION: Document Title-CAP 2010 Result 3 Education
2 Excel sheet name: SUMMARY: Document Title- Summary of UN Agencies contributions to CAPs 2010
3 Excel sheet name: Progress: Document Title- CAP 2010 Result 1 Good Governance
File name: CAP 2010_Environment TG
1 Excel sheet name: Environment: Document Title-CAP 2010 Result 4 Environment 22/01/2010
2 Excel sheet name: SUMMARY: Document Title- Summary of UN Agencies contributions to CAPs 2010

File name: CAP 2010_Governance TG
1 Excel sheet name: Progress: Document Title- CAP 2010 Result 1 Good Governance.
2 Excel sheet name: SUMMARY: Document Title- Summary of UN Agencies contributions to CAPs 2010

File name: CAP 2010_Hiv TG:
2 Excel sheet name: SUMMARY: Document Title- Summary of UN Agencies contributions to CAPs 2010

File name: CAP 2010_HPN TG
2 Excel sheet name SUMMARY: Document Title- Summary of UN Agencies contributions to CAPs 2010
3 Excel sheet name Progress: Document Title- CAP 2010 Result 1 Good Governance

File name: CAP 2010_SG & SP TG
1 Excel sheet name SP SG: Document title: CAP 2010 Result 5 Rwandan Population benefits from Economic Growth and is less vulnerable to social and economic shocks
2 Excel sheet name SUMMARY: Document Title- Summary of UN Agencies contributions to CAPs 2010
3 Excel sheet name Progress: Document Title- CAP 2010 Result 1 Good Governance

FOLDER NAME: Monitoring Field Visit Reports

FOLDER NAME: 2008

FOLDER NAME: RH
File name: AMERICANS FOR UNFPA 2008: Document Title- AMERICANS FOR UNFPA
File name: DN Mission HOPITAUZ October 08: Document Title- Mission Report
File name: TRIP AM_DN Rubavu 15 08 08; Document title: Field visit report
File name: TRIP Prual_DN Karongi 22-23 08 08; Document title: Field visit report

FOLDER NAME: HIV
File name: NOTE TO THE FILE supervision visits for CNLS HIV and AIDS programs at district level
File Name: NOTE TO THE FILE rapport de supervision des districts par la CNLS et UNFPA
File name: Rapport generel de descentes de supervision des districts, Mai-Juin 2008 : Document Title: Rapport de la Tournee de supervision de la CNLS dans des CDLS
FOLDER NAME: 2009
File name: AM TRIP report Kiziba 020409: Document title Field Visit Report
File name: Join field visit rapport_GATSIBO_MAY 2009: Document title Field Visit Report
File name: TRIP_KAGUGU-1: Document title Trip Report, 23/06/2009
File name: Trip Report JADF: Document title Title Report, 22/05/2009
File name: Trip report JAF Meeting: Trip Report 12/05/2009
File name: Trip report Muhura poste Secondaire 19.06.09: Trip Report 08/06/2009

FOLDER NAME: 2010
File name: Report Field visit Rubavu: Document Title -Field Visit Report, 20/04/09(doc in French)
TRIP AM Rusizi et Nyamasheke 13 au 14 mai 2009; Document Title- Field Visit Report, 17 Mai 2009
FOLDER NAME : OMPS
EMPTY
FOLDER NAME: Quarterly Reports
FOLDER NAME: 2008 Q 4
File name: 17th February quarterly programme report RHR: RWANDA 2008 4TH QUARTERLY CP PROGRESS REPORT. (Programme performance by thematic area)
File name: DRAFT Quarterly report end 2008 20022009_revised Rob -1
File name: DRAFT Quarterly report RH2
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FOLDER NAME: IPs
File name: comments MIGEPRFOF Q 1 report
File name: Comments MIGEPRFOF Q 2 report: Document Title- Comments on Quarter 1 report MIGEPROF; By M&E unit (KW)
File name: Comments MIGEPRFOF Q 2 report: Document Title- Comments on Quarter 2 report MINECOFIN; By M&E unit (KW)
FOLDER NAME: UNFPA
File name: Q1 M&E report 2009: Doc couldn’t open
FOLDER NAME: 2010
FOLDER NAME: Q1
Excel File name: Q1 Activity Report form
File name: Q1 DRAT 06042010: Document title: RWANDA 2010 1st QUARTERLY CP PROGRESS REPORT
File name: Q1 DRAFT 15042010:
File name: Q1 DRAFT _RHR_2010_Draft0
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File name: Q1_RHR_2010_Draft VM inputs
FOLDER NAME: Q2
FOLDER NAME: CO
File name: Semester 1 2010 CO Rwanda: document title: COUNTRY PROFILE INFORMATION, Jan – June 2010
FOLDER NAME: M&E UNFPA
File name: AWP Monitoring tool, 2010 2nd quarter Karongi; Annex 1: The Work Plan Monitoring Tool

File name: JYP Report CEPEX 2nd quarter new format DRAFT Final; Document Title: Project Reporting Format/2010 2nd Quarter Report


FOLDER NAME: MINIYOUTH

File name: AWP Monitory Tools RUSIZI: Annex 3: THE WORK PLAN MONITORING TOOL; Reporting period: 2010, 2nd quarter, RUSIZI


UNDER FOLDER NAME Q2:


FOLDER NAME: Q3

File name: comments MIGEPROF Q3 report: Document title-Comments on Quarter 3 report MIGEPROF, By: M&E unit (KW)

File name: comments MINIYOUTH Q3 Report: Document title-Comments on Quarter 3 report MIGEPROF, By: M&E unit (KW)

File name: Comments MOH Q3 Report: Document title-Comments on Quarter 3 report MoH; By: M&E unit (KW)

File name: JYP Implementation progress report 3rd Quarter October 17(current):

File name: MOH REPORT Q3: Annex 3: The Work Plan Monitoring Tool; Reporting period: Quarter 3; Component: Reproductive Health and Rights

Q3 MIGEPROF: The Work Plan Monitoring Tool; Reporting period: Quarter 3, Quarter III, 2010 (July-September 2010); Component: Gender

UNDER THE FOLDER NAME 2010

File name COUNTRY_PROFILE_REPORTING FORMAT, 2010

File name: QUARTERLY COUNTRYPROGRAMME PROGRESS REPORT Q1 2010

File name: QUARTERLY COUNTRYPROGRAMME PROGRESS REPORT Q1 2010 - I-FORMAT-IM

File name: Standard Progress report format; Annex 1: Standard Progress Report

UNDER THE FOLDER NAME QUARTELY REPORTS:

File name: RWANDA 2009 1ST QUARTERLY COUTNRY PROGRAMME PROGRESS REPORT

FOLDER NAME RBM Trainings for IPs

FOLDER NAME: M&E CD TRAINING

FOLDER NAME RB PRESENTATIONS

File name: Note technique formation M&E training hospitals

File name: technical Note M&E and finance training Sept 08

FOLDER NAME: Review Meetings
FOLDER NAME: 2010 REVIEW
FOLDER NAME: REVIEW MEETING FILES
File name: Annual review meetings TORs
File name: Annual review presentation 2010
File name: Agenda
File name: Annual presentation 2010
File name: Report of the annual review meeting of the GoR

UNDER THE GENERAL FOLDER: Document for end line evaluation
File name: 5th CPD final evaluation report June 2007
File name (Pdf): CLE DaO Interim Report _17rb
File name (Pdf): Common Operation Document FINAL 291107
File name (Pdf): COR 2007
File name: CPD_Rwanda Final As of 22_12_2007
File name: EDPRS 2008 -2012 English version
File name: FINAL MTR REPORT TO BE PRINTED: Mid Term review report UNFPA Rwanda 6th CP, September 2010
File name: Strategic Plan English
File name: UNDAF Final Document _070731
File name: Vision 2020 Umurenge
OTHER DOCS ON CD
File name: UN Rwanda Annual report 2009 -3
File name: M&E framework with district value
File name: M&E framework with district value UPDATED

1. BACKGROUND
Rwanda is committed to becoming a middle income economy by 2020 through implementing the priorities identified in Vision 2020 and the medium term Economic and Poverty Reduction Strategy (EDPRS).

In their support to the Government of Rwanda (GoR), the United Nations (UN) agencies in Rwanda, operating within the One UN framework, have developed the United Nations Development Assistance Framework (UNDAF) as the strategic response to the national priorities outlined in the Vision 2020 and EDPRS.

The thematic priorities and indicators included in both Vision 2020 and the EDPRS are consistent with the Millennium Development Goals (MDGs).

To operationalize the UNDAF a Common Operational Document (COD) has been developed and clarifies which agencies are responsible of what Outcomes and implementation modalities.

The UNFPA 6th Country Programme (CP) was derived from UNDAF and both documents are aligned to the National priorities, the MDGS, the ICPD Programme of Action, the Maputo Declaration on Continental Policy Framework on Sexual and Reproductive Health and Rights and UNFPA Strategic Plan.

The 6th CP is five year Programme which commenced in January 2008 and ends in December 2012. The budget for the 6th CP (CP) is $30 millions USD of which $10 is from regular resources and $20 million is through co-financing modalities.

The 6th CP was developed into three major programme components; Reproductive Health, PD and Gender and is implemented at both National and decentralized levels. The programme contributes to the achievement of four of the five UNDAF results. Under each thematic area, the Outcomes and Outputs of the CP are as follows:

Reproductive Health
Activities for this component are implemented both at national and district levels is contributes to 3 UNDAF Results.

*UNDAF Result 1: Good governance enhanced and sustained*

- **UNDAF Outcome 1.3.** Decentralization & Participation. An effective decentralized administration with emphasis on democratic participation and representation
- **UNDAF Output 1.3.2.** Mechanisms for participation and representation of children, young people, women, PLHIV, disabled and historically marginalized people in decision making, including elections at national and decentralized level strengthened
- **UNDAF Result 2. The mortality due to child and maternal morbidity, the incidence and impact of HIV and AIDS and other major epidemics are reduced, and the growth of the population is slowed down**
- **UNDAF Outcome 2B1:** Effective Health systems. Equity, Effectiveness and efficiency of the national health system improved
• **CPD Outcome**: Improved quality, effectiveness and efficiency of the health system, including nutrition, reproductive health, maternal and child health, and family planning services

• **UNDAF Output 2B.1**: National policies, strategies and standards for health and nutrition, developed based on research and evidence and with a focus on equity and financing

• **CPD Output**: Increased capacity of the social and health system to provide a complete, integrated health-care package, including maternal, child, adolescent and youth health services appropriate to different levels and targets

• **UNDAF Outcome B2.2**: Health practices: Adoption of healthy practices and improved access to and use of quality health services

• **UNDAF Output 2B.2.1**: Capacity of health services and CSOs to promote and provide a complete and integrated package of health & nutrition services appropriate to different target groups and levels strengthened

• **CPD Output**: Strengthened capacity for community mobilization of community organizations, faith-based organizations and traditional leaders

• **UNDAF Output 2B.2.3**: Capacity at national and decentralized levels for rapid response to epidemics and other health & nutrition emergencies strengthened

• **UNDAF Result 5**: Rwandan population benefits from food security and economic growth, including productive employment, and is less vulnerable to natural, social and economic shocks

• **UNDAF Outcome 5B.2**: Disaster Management. Effective disaster management system in place to minimize risks and respond to shocks

• **UNDAF Output 5B.2.1**: National and local capacities for disaster management (disaster risk reduction, early warning system, mitigation and response) strengthened.

**HIV/AIDS**

**UNDAF Result 2**: The mortality due to child and maternal morbidity, the incidence and impact of HIV and AIDS and other major epidemics are reduced, and the growth of the population is slowed down

• **UNDAF Outcome 2A1**: Coordination, planning, M&E and partnership in line with the three ones principles, leadership and oversight for an expended HIV response by national and local coordinating institutions strengthened and sustained

• **UNDAF Output 2A1.1**: National capacities to develop/review national policies, plans and strategies based on evidence (research & M&E) strengthened

• **UNDAF Output A1.2**: National and regional coordination of and partnership on HIV with public institutions, civil society, private sector and donors strengthened

• **CPD Output**: Increased capacity of national and civil society institutions to provide participatory, youth-friendly, HIV prevention services, including life skills and peer education for in- and out-of-school youth

• **CPD Output**: Increased access to a comprehensive package of prevention services (information, education and communication; post-exposure prophylaxis; sexual and reproductive health; sexually transmitted infection management; and voluntary counselling and testing) that addresses high-risk groups and the drivers of the epidemics

• **UNDAF Outcome 2A2**: Prevention of HIV. Protective behaviours adopted and effective preventive services utilized by HIV-exposed population especially the youth and the women
• **CPD Outcome:** People, especially youth and women, adopt protective behaviour and utilize effective preventive services
• **CPD Output:** Increased access to male and female condoms and new HIV prevention technologies and approaches
• **UNDAF Output 2A2.1:** National capacities (public, private, civil society) to stimulate individual and social change and provide a comprehensive package of preventive interventions, including new preventive technologies with a focus on the most at risk populations and young people increased

**Population & Development**

*UNDAF Result 1: Good governance enhanced and sustained*

• **UNDAF Outcome 1.2:** Evidence based policy making and accountability: Effective policy and socio-economic planning and accountable, transparent management of public resources enhanced
• **CPD Outcome.** The use of high-quality, disaggregated data will guide policy and socio-economic planning
  • **UNDAF Output 1.2.2:** National capacities to generate, manage, analyze and disseminate gender disaggregated socio-economic data for decision making at all levels strengthened
  • **UNDAF Output 1.2.2:** National Participatory Planning, Monitoring and Evaluation system to track progress disaggregated by sex towards MDG and EPRS targets strengthened
  • **CPD Output:** Information systems, including for population data, are fully developed and operational in the public sector

• **UNDAF Result 3:** All children in Rwanda acquire a quality basic education, knowledge and skills for knowledge based economy and enriched cultural society.
• **UNDAF Outcome 3.2:** Key learning outcomes for Children including life-skills and competencies for long life learning achieved.
• **CPD Outcome.** An effective educational management system is in place
  • **UNDAF Output 3.2.1:** Curriculum reviewed and strengthened to include life skills and outcome based competencies, including a focus on literacy and culture
  • **UNDAF Output 3.2.2:** Pre and in service teacher training systems strengthened to promote effective learning, child centred teaching methodology and a culture of reading
  • **CPD Output.** The institutional capacity for school planning and costing at the district level is strengthened, using tools that analyse population dynamics
• **UNDAF Outcome 3.3:** Effective system. The education system is effectively planning, analysing and coordinating the education sector to deliver quality education to all children.
  • **UNDAF Output 3.3.2:** Evidence-based, gender and equity focused national policies, plans and strategies developed.

**Gender Equality**

*UNDAF Result 1: Good governance enhanced and sustained*

• **UNDAF Outcome 1.3.** Decentralization & Participation. An effective decentralized administration with emphasis on democratic participation and representation
  • **UNDAF Output 1.3.1:** National and decentralised level capacities (public and civil society) in gender-sensitive planning, budgeting and financial management strengthened
UNDAF Outcome 1.4. Gender equality: The gender equality dimension is effectively mainstreamed in national development plans and corresponding strategies for the elimination of gender based discrimination and disparities

CPD Outcome: All public and private institutions apply gender-equality principles and standards in their performance, practices and behaviour.

- UNDAF Output 1.4.1. Evidence informed policy framework for ensuring gender equality and combating other forms of discrimination against marginalized groups strengthened
- UNDAF Output 1.4.2: Capacities and mechanisms of public institutions and civil society to advocate for, coordinate, monitor and evaluate policies and actions related to gender equality strengthened at central and decentralised levels
- CPD Output: The institutional capacity of key development actors is strengthened in the areas of coordination, gender-based analysis, planning, policy formulation, monitoring and evaluation

1. PROGRAMME COORDINATION
The MINECOFIN (MINECOFIN) is the overall coordinating body of the programme and the implementing partner for the PD component which has two other implementing partners namely the RPRPD and FFRP. The MINISANTE (MoH), oversee the reproductive health component, including 22 district hospitals and MINIYOUTH. In 2010 a Mid Term review of the programme recommended to work only 5 Districts so as to be more focused and efficient. The CNLS is the implementing partner (IP) for the HIV/Aids component. Finally, the MIGEPROF oversees the gender component.

2. PURPOSE OF THE EVALUATION
The overall purpose of this end line evaluation is to assess and document the achieved results, draw lessons learnt, identify challenges and make recommendations on alternative cost efficient strategies to be used by implementing partners and UNFPA in planning the next CP of cooperation between GoR and UNFPA.

3. EVALUATION SCOPE:
The evaluation will be conducted for a period of two months and will cover all interventions, including joints projects, from the three major components stipulated by the CPD (gender equality, reproductive health, population and development) from 2008 to 2011. Although the programme was designed to be implemented up the year 2012 the evaluation will assess the achieved results up to the year 2011 and give the trend to achieving the expected Results. The assessment will include all Implementing Partners (IPs) Government structures and NGO, CBOs both at Central and decentralized levels.

The specific objectives of the evaluation are to:
1. Assess to which extent the planned Results have been achieved by the 6th CP
2. Assess the extent to which the 6th CP (CP) has contributed to the defined results of the United Nations Development Assistance Framework (UNDAF) 2008-2012 and to national priorities as per EDPRS. (contribution analysis)
3. Assess and analyse the impact of the new implementation strategies recommended by the MTR, on the effectiveness and efficiency of the programme.
4. Assess the alignment and effectiveness of strategies used to contribute to the achievement of national development priorities identified in EDPRS.
5. Assess to what extent are the objectives of the Programme still consistent with national priorities and beneficiaries/shareholders requirements.

6. Assess the alignment and contribution of joint programmes that UNFPA contributes to in achieving CP results.

7. Assess how gender, human rights culture and young people have been considered in the CP implementation within the context of DaO.

8. Examine how effectively government systems have been utilized and how this has contributed to the results, as per the Paris Declaration.

9. How economically were resources used in terms resources/inputs (such as funds, expertise, time) were converted into results?

10. Analyse the probability of continued long terms benefits obtained change after completion of the programme. (Sustainability)

11. Provide recommendations to inform the development of the 2013-2018 CP in the context of DaO.

**Key questions to be answered**

**Relevancy**

1. To what extent the 6th CP is still aligned to National priorities (EDPRS, Vision 2020) Millennium Development Goals?

2. How relevant and effective has the CP been in contributing to achievement of UNDAF results and national priorities?

3. To what extent the formulated results of the CP are coherent to solve the problems identified needs of the beneficiaries?

**Effectiveness**

1. What are the results achieved vs. planned objectives of the programme?

2. How effectively has the CO engaged in the UN reform processes?

3. To what extent has the joint programme modality (in the context of DaO) contributed to achievement of CP results?

4. How effectively has the CO engaged in upstream and downstream work?

5. How effectively the coordination mechanisms contributed to the achievement of expected results?

**Efficiency**

1. What are the results achieved vs. resources (human, time, financial) invested?

2. To what extent has gender, mainstreaming been addressed in the design and implementation of the CP?

3. Are the strategies cost effective and efficient to get expected results?

4. How efficient are the processes and systems including application of results based management (RBM) in achieving CP results?

**Impact**

1. What change did the implementation of the programme have had on the beneficiaries?

**Sustainability**

1. To what extent the IPs and Government structures are willing and are capable to scale up the programmes activities?
2. How sustainable is the progress made and achievements. Can the results achieved be scaled up and/or sustained?
3. To what extent the programme build capacity for Government structures to be able to maintain the change made by the programme interventions if any?
4. What were the challenges if any to scaling up progress made and achieved results?
5. What are the key lessons learnt and best practices that can contribute to knowledge base of the UNFPA and partners and be applied in future programme and policy development?
6. What are the areas of UNFPAs’ comparative advantage that the CO should focus the 7th CP of support on to Rwanda in the context of the new aid environment and in the context of DaO?

Stakeholders: UNFPA staff, UN agencies, selected Development Partners, Implementing partners (state and non-state actors including CSOs).

1. EVALUATION METHODS
The evaluation will use both quantitative and qualitative methods in data collection and analysis (however when possible quantitative methods should be preferred). The data collection techniques will be mainly:
- Desk review and content analysis of key documents, a list of documents to be used is provided in the annex 1
- In depth interviews with key stakeholders: IPs, beneficiaries, UNFPA CO staff.
- Participatory and non participatory observation: visits to selected project sites.
- Focus group discussions with project partners and beneficiaries.

Key steps for the evaluation:
Preparation
This involves briefing orienting and clarification to evaluators of the key concepts including Delivering as One approach, CPD, COD and their relation with EDPRS.

Inception Report
- The evaluation team will review existing documents, meet the EMG (Evaluation Management Group) and prepare a brief inception report no more than 6 days from the day of being contracted. The inception report will include a detailed work plan, evaluation questions and tools. An inception report by consultants will be presented to EMG for discussion before the evaluation team moves to next phases.

Data collection
- Desk reviews and analysis of key and relevant documents including, UNDAF and CP MTR, Joint Review Meetings reports with CEPEX, implementing partners AWPs, progress reports, DHS etc.
- Interviews with key informants, UNFPA staff, UN agencies, selected Development Partners, Implementing partners (Government and non Government Organizations including FBOs, CBOs) and beneficiaries.

Analysis
- Evaluators will analyse collected data/information, perform statistical tests where necessary, get analytical conclusions and recommendations, do triangulation of data to seek for accuracy of data where necessary and enrich the findings.
Reporting

- Evaluators will present and submit report according to the agreed format to the UNFPA Management and EMG.

Dissemination

- Dissemination of the findings to the appropriate stakeholders and beneficiaries will be done

LIST OF KEY DOCUMENTS: CP Document (CPD)

1. COD
2. UNDAF
3. EDPRS, VISION 2010
4. MTRs reports for CPD and UNDAF
7. CLE report
9. Quarterly and Annual reports by IPs
11. Joints Programme Documents submitted to RC
16. 5th CP Final evaluation report
17. RBM training for IPs reports
18. 2011 Planning process documents

19. COMPETENCIES REQUIRED:

a. EVALUATION MANAGEMENT

The Evaluation team will work directly and closely with the Evaluation Management Group (EMG) which will be established to provide overall support (logistics, meetings with stakeholders, dissemination, and debriefing meetings) and responsible for quality assurance of the evaluation process. Evaluation Management Group, which is delegated by UNFPA management, will work closely with evaluation team to ensure quality of the evaluation. The EMG team will meet with evaluation team at key points to discuss progress and address any challenges faced. The final report will be submitted to the UNFPA representative for approval. UNFPA management will then prepare management response to the evaluation findings and recommendations.

b. EVALUATION TEAM

This evaluation requires a team of four consultants (1 International and the team leader and 3 Nationals to cover all three components).

The team should have the following profile(s).

International Consultant (a team leader)
• At least a Masters degree or equivalent level in one of the following fields: Health Economics, Social Policy, Public health, Gender, Demography, Development Studies, or relevant Social Sciences with at least 8 years experience.
• International experience of at least 10 years is required and past experience in working with the UN is an added advantage.
• Past experience as a team leader in a related assignment (s).
• Proven experience in policy development and analysis around reproductive health, gender, population issues and poverty reduction strategies for national consultants highly desirable
• Experience and understanding of UN programming processes. Knowledge of UN reforms and Delivering as One highly desirable.
• Experience and skills in using evidence-based, knowledge base creation and ability to develop systems for improved performance.
• Experience on evaluation of UN supported programmes will be an added advantage.
• Excellent report writing, communication, interviewing and computer skills.

National Consultants
• Master’s Degree in Population, Demography, Gender Studies, Public Health, Law, Development Studies related subject, or any other relevant field.
• Experience in the evaluation of UN supported programmes will be an added advantage.
• Proven experience in policy development and analysis around reproductive health, gender, population issues and poverty reduction strategies highly desirable.
• Experience and skills in using evidence-based, knowledge base creation and ability to develop systems for improved performance.
• Proven experience in programme evaluations and assessments.
• Evidence of an analytical work in the subject matter.
• Knowledge and experience with different funding modalities for support to the government (e.g. Basket funding under SWAps).
• Excellent report writing, communication, interviewing and computer skills.

DELMERABLES/OUTPUTS
a) Inception report with detailed evaluation work plan, evaluation questions and tools, a maximum of five days after contract award.
b) Preliminary evaluation report with key findings within 30 days from start date.
c) Final evaluation report with key lessons learnt and recommendations to be submitted 5 days after presentation of the preliminary findings.
Annex 2: List of People Interviewed

ONE UN OFFICE /UN AGENCIES
1. Mr. Aurelien A Agbenonci  Office of the UN Resident
2. Ms Margaret Gulavic –UNDP
3. Ms Suzan Kiragu–UNAIDS

UNFPA
4. Mr Cheikh Fall Deputy Representative -UNFPA
5. Ms. Annet Baigana Operation’s Manager- UNFPA
6. Robert Banamwana M&E Officer - UNFPA

DEVELOPMENT PARTNER
7. Ms Dinah Musindarwezo–Norwegian People’s Aid

NGO
8. Dr Laurien Nyabienda –Executive Director ARBEFF clinic
9. Ms Radegonde Ndjuru –Imbuto Foundation
10. Ms Murumunawabo –Programme Officer Imbuto Foundation

CENTRAL GOVERNMENT
11. Mr Rugwabiza Leonard DG-MINECOFIN
12. Mr. Nkusi Ronald –External Funding Unit – MINECOFIN
13. Dr Fidele Ngabo –Project Coordinator –MINISANTE
14. Mr Mwijukye James –National Coordinator –MIJESPOC
15. Ms Egidia –Gender Cluster Coordinator MIGEPROF
16. Ms Odette Mbabazi/Acting Director Corporate Services
17. Dr. Anita Assimwe- RBC/CNLS
18. Dr. Nyamwasa Daniel –One Stop Centre Kacyiru
19. Patrick Mico – Gender Monitoring Office

Parliament
20. Dr Ntawukurirayayo Jean Damascene- The Parliamentarian’s Network for Population and Development
21. Senator Marie Mukantabana- The Rwandan Women’s Parliamentary Forum
22. Ms. Speciose Nyiraneza -The Rwandan Women’s Parliamentary Forum
23. Ms. Prisca- The Rwandan Women’s Parliamentary Forum

RALGA
24. Mr. Theogene Karake-Rwandan Association of Local Government Agencies

District
25. Mr. Jerome Byukusenge –Director of Planning, M&E Rubavu
26. Birorimana Jean Paul –Director of Planning, M & E Ngororero
27. Ms. Clotilde Nyiraneza-Vice Mayor In charge of Social Affairs, Ngororero
28. Mr. Albert Ntagara- CDLS Officer
29. Mr Muhire Nathan –Director of Planning, Karongi

District Hospitals
30. Ms. Hakizimana Sophonie –Nyagatare Hospital
31. Dr. Rukunda K.Benon-Medical Director of Nyagatare Hospital
32. Dr. Patrice Karumugabo –Director of Hospital, Rubavu
33. Dr Jesse C TABARANZA- Surgeon–Mugonero Hospital, Karongi
34. Mr Mushonda Gervias – Rwamagana Hospital  
35. Dr Damien Nsabimana – Director of Hospital Kibogora  
36. Dr Alfred Twagirumungu – Director of Hospital Gihundwe  

**Managers YFCs**  
37. Mr Sibomana J de Dieu – Rusizi Youth Friendly Centre, Manager  
38. Ms Manirarora Announce – Manager Karongi Youth Friendly Centre  

**Focus group discussions**  
39. Female members of Agaseke Cooperative under Kigali City Centre  
40. Former Female Sex Workers in Rubavu  
41. Youth at Youth Friendly Centre in Karongi  
42. Community Health Workers Karongi  
43. Community Health Workers Rusizi  
44. District Partners in Rusizi  
45. UNFPA Programme Officers
## Annex 3: Evaluation Matrix

### UNDAF Result 1: Good Governance Enhanced and Sustained

<table>
<thead>
<tr>
<th>Objective</th>
<th>Specific Question</th>
<th>Indicator</th>
<th>Data Source</th>
<th>Evaluation Design</th>
<th>Sampling Plan</th>
<th>Data collection Instruments</th>
<th>Data analysis Plan</th>
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</thead>
<tbody>
<tr>
<td>Evidenced based policy making using quality disaggregated data strengthened</td>
<td>To what extent has quality disaggregated data been used to inform evidenced based policy making and to guide policy and socioeconomic planning?</td>
<td>Number of surveys, studies, assessments and reports produced for policies and planning by national statistical system</td>
<td>NISR</td>
<td>NA</td>
<td>NA</td>
<td>Questionnaire</td>
<td>Count/trend analysis</td>
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<td></td>
<td>Number of staff trained in data collection, processing and dissemination</td>
<td>NISR Activity Report</td>
<td>Desk Research</td>
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<td>NA</td>
<td>Questionnaire</td>
<td>Count/trend analysis</td>
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<tr>
<td></td>
<td>Number of published documents and studies based on reproductive health, population and gender data</td>
<td>UFPA reports</td>
<td>Desk Research and Interviews</td>
<td>NA</td>
<td>Questionnaire</td>
<td>Count/trend analysis</td>
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<tr>
<td></td>
<td>Number of districts with civil registration system established and functional</td>
<td>NISR Activity Reports</td>
<td>Desk Research and interview</td>
<td>NA</td>
<td>Questionnaire</td>
<td>Count/ trend analysis</td>
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<tr>
<td></td>
<td>Number of districts with local disaggregated database with an emphasis on young people, women and people with disabilities</td>
<td>District Reports/ Ministry LG Evaluation data</td>
<td>Desk Research Purposive sample survey</td>
<td>NA</td>
<td>Questionnaire</td>
<td>Count</td>
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</table>

### All children in Rwanda acquire a high quality basic education and skills for a knowledge-based economy

<table>
<thead>
<tr>
<th>Objective</th>
<th>Specific Question</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Key Learning for Children including Life-skills for lifelong learning achieved The Institutional Capacity for School Planning and Costing at the District level is Strengthened , using Tools that analyse Population Data</td>
<td>To what extent have skills for lifelong learning been introduced into the school curricula?</td>
<td>No of new outcome based curricula developed</td>
<td>EMIS NCDC</td>
<td>Desk Research</td>
<td>N/A</td>
<td>Interview</td>
<td>Count</td>
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<tr>
<td></td>
<td>Pupil/textbook Ratio</td>
<td>EMIS</td>
<td>Desk Research</td>
<td>N/A</td>
<td>N/A</td>
<td>Count/Trend Analysis</td>
<td></td>
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</tbody>
</table>

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<tbody>
<tr>
<td>To what extent are tools that analyse population data being used in school planning?</td>
<td>% of District Development Plans based on population projections</td>
<td>District Reports/ Ministry LG/ Ministry Education Evaluation data</td>
<td>Desk Research Purposive sample survey</td>
<td>NA</td>
<td>100% sample (5) Districts UNFPA works with in W Province, sample withdrawing from (2)</td>
<td>Interview Questionnaire Count/Trend analysis Count</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of districts that develop a multi-year plan on educational needs (including costing based on population dynamics) that emphasises the needs of girls.</td>
<td>District Reports/ Ministry Education Evaluation data</td>
<td>Desk Research Purposive sample survey</td>
<td>NA</td>
<td>100% sample (5) Districts UNFPA works with in W. Province, sample withdrawing from</td>
<td>Questionnaire Questionnaire Count/Trend Analysis Count</td>
<td></td>
</tr>
<tr>
<td>Effective Educational Management System Operational Participation of NGOs, FBOs, PSF in national and District Plans for Education strengthened</td>
<td>What is the involvement of NGOs, FBOs and PSF in District Educational planning</td>
<td>No of Education NGO Forum and Networks in Place</td>
<td>EMIS Evaluation</td>
<td>Desk Research Purposive sample survey</td>
<td>NA</td>
<td>100% sample (5) Districts UNFPA works with in W. Province, sample withdrawing from</td>
<td>Interview Questionnaire Count/Trend analysis Count</td>
</tr>
<tr>
<td></td>
<td>Number of BGOs and FBOs in Education Sector</td>
<td>EMIS Evaluation</td>
<td>Desk Research Purposive sample survey</td>
<td>NA</td>
<td>100% sample (5) Districts UNFPA works with in W. Province, sample withdrawing from</td>
<td>Interview M of E Questionnaire Count/Trend analysis Count</td>
<td></td>
</tr>
<tr>
<td>Evidenced-based Development Plans based on Population Projections</td>
<td>To what extent are District Education Plans informed by evidence and population projections?</td>
<td>% of District Plans Based on Population Projections</td>
<td>EMIS Evaluation</td>
<td>Desk Research Purposive sample survey</td>
<td>NA</td>
<td>100% sample (5) Districts UNFPA works with in W. Province, sample withdrawing from</td>
<td>Interview M of E Questionnaire Count/Trend analysis Count</td>
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<tr>
<td>People’s Participation in Democratic Processes at National and Decentralised Levels is increased. Mechanisms for Participation of Women and Gender Advocates in Democratic Processes Enhanced.</td>
<td>What is the extent of people’s participation in democratic processes at local and national levels?</td>
<td>No of women in decision making positions at central and local levels</td>
<td>Election results</td>
<td>Desk Research</td>
<td>NA</td>
<td>NA</td>
<td>Count/Trend analysis</td>
</tr>
<tr>
<td>People’s Participation in Democratic Processes at National and Decentralised Levels is increased. Mechanisms for Participation of Women and Gender Advocates in Democratic Processes Enhanced.</td>
<td>To what extent and in what ways are public and private institutions applying the principles of gender equity?</td>
<td>No of development partners with gender focal points trained and equipped with planning tools</td>
<td>Development Partners Strategic Planning Documents Evaluation</td>
<td>Desk Research</td>
<td>Purposive sample survey</td>
<td>NA</td>
<td>Interviews, Questionnaire</td>
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</table>

**Mortality due to Child and Maternal Morbidity, incidence and impact of HIV and AIDS and other major epidemics are reduced and the population growth is slowed down**

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<tr>
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<tr>
<td>Effective health system: quality, effectiveness and efficiency of the health system, including Nutrition, RH, Maternal and Child Health and FP Service Improved quality of the health system, including Nutrition, RH, Maternal and Child Health and FP Service</td>
<td>How effective and efficient is the health care system including for nutrition, RH, MH, CH and FP services?</td>
<td>Government Budget allocated to health</td>
<td>National Budget</td>
<td>Desk Research</td>
<td>NA</td>
<td>NA</td>
<td>Trend Analysis</td>
</tr>
<tr>
<td>Improved Health Care, nutrition and hygiene practices at family and community level.</td>
<td>Have health care, nutrition and hygiene practices improved at family and community levels?</td>
<td>% of assisted deliveries</td>
<td>DHS 2005, IDHS 2007/8, DHS 2010</td>
<td>Desk Research</td>
<td>NA</td>
<td>NA</td>
<td>Trend Analysis</td>
</tr>
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<tr>
<td>Improved capacity of the local health care system to provide a complete, integrated health-care package , including child, adolescent and youth health service appropriate to different targets</td>
<td>Has the capacity improved of the local health care system to provide an integrated health-care package, including child, adolescent and youth health service appropriate to different targets?</td>
<td>Number of health facilities providing complete package</td>
<td>M of H Reports Evaluation</td>
<td>Desk Research Purposive sample survey</td>
<td>NA</td>
<td>NA</td>
<td>Trend Analysis</td>
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<td>100% sample (5) Districts UNFPA works with in W. Province, sample (2) withdrawing from</td>
<td>NA</td>
<td>Interview</td>
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<td>NA</td>
<td>Trend Analysis</td>
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<tr>
<td></td>
<td>% of Obstetric gynaecological admissions for post-abortion care</td>
<td></td>
<td>M of H Reports/HMIS Evaluation</td>
<td>Desk Research Purposive sample survey</td>
<td>NA</td>
<td>NA</td>
<td>Trend Analysis</td>
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<td>NA</td>
<td>Trend Analysis</td>
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<tr>
<td></td>
<td>% of births attended by trained health care personnel</td>
<td></td>
<td>Desk Research</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>Trend Analysis</td>
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<td>NA</td>
<td>Trend Analysis</td>
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<td></td>
<td>Number of health facilities with youth friendly services</td>
<td></td>
<td>M of Y Reports Evaluation</td>
<td>Desk Research Purposive sample survey</td>
<td>NA</td>
<td>NA</td>
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<td>Trend Analysis</td>
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<tr>
<td></td>
<td>Strengthened Capacity for Community Mobilisation</td>
<td></td>
<td>M of H Reports/HINS Evaluation</td>
<td>Desk Research Purposive sample survey</td>
<td>NA</td>
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<td>Trend Analysis</td>
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<tr>
<td></td>
<td>% of Umuduganda with at least two trained community health workers</td>
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<td>100% sample (5) Districts UNFPA works with in W. Province, sample withdrawing from</td>
<td>NA</td>
<td>Interview</td>
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<td>NA</td>
<td>Trend Analysis</td>
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<tr>
<td></td>
<td>% of Faith-based organizations promoting RH and FP at the community level</td>
<td></td>
<td>Evaluation</td>
<td>Purposive sample survey</td>
<td>100% sample (5) Districts UNFPA works with in W. Province, sample withdrawing from</td>
<td>Interview</td>
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<td></td>
<td>National policies, strategies and standards for health, including ECD, IMNCL, Community Security, water, sanitation, Nutrition, RH and FP developed and implemented</td>
<td></td>
<td>Policies and standards Desk Research</td>
<td>M of H Annual Reports</td>
<td>NA</td>
<td>Interview</td>
<td>Count</td>
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<tr>
<td>Health Practices, Health Care, Nutrition, and hygiene practices at family and community levels improved</td>
<td>Have health practices Health Care, Nutrition, and hygiene practices at family and community levels improved? Has the capacity health services and community based organizations to promote optimal health, FP, nutrition and hygiene practices been strengthened?</td>
<td>No of health facilities providing complete package</td>
<td>M of H Reports/EDPRS M + E Evaluation</td>
<td>Desk Research Purposive sample survey</td>
<td>NA 100% sample (5) Districts UNFPA works with in W. Province, sample withdrawing from</td>
<td>NA Interview</td>
<td>Trend Analysis</td>
</tr>
<tr>
<td>Capacity of CBOs, FBOs and traditional healers strengthened</td>
<td>Has the capacity of CBOs, FBOs and traditional healers to promote optimal health, FP, nutrition and hygiene practices been strengthened?</td>
<td>% of HF implementing community IMNCI</td>
<td>M of H Reports/EDPRS M + E Evaluation</td>
<td>Desk Research Purposive sample survey</td>
<td>NA 100% sample (5) Districts UNFPA works with in W. Province, sample withdrawing from</td>
<td>NA Interview</td>
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<tr>
<td></td>
<td></td>
<td>Number of Umudugudu with trained community health workers</td>
<td>M of H Reports/EDPRS M + E Evaluation</td>
<td>Desk Research Purposive sample survey</td>
<td>NA 100% sample (5) Districts UNFPA works with in W. Province, sample withdrawing from</td>
<td>NA Interview</td>
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### Mortality due to Child and Maternal Morbidity, incidence and impact of HIV and AIDS and other major epidemics are reduced and the population growth is slowed down

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<tr>
<td>Coordination, M&amp;E and partnership in line with the three one principles, leadership, and oversight for an expanded HIV response national and local coordinating institutions strengthened and sustained</td>
<td>Is coordination, M&amp;E and partnership in line with the Three One's principles leadership, and oversight for an expanded HIV response National and local coordinating institutions strengthened and sustained? People especially youth and women adopt protective behaviour and utilize effective prevention services</td>
<td>% of females and males (aged 15-24) using condoms for HIV prevention</td>
<td>DHS Evaluation</td>
<td>Desk Research</td>
<td>NA</td>
<td>100% sample (5) Districts UNFPA works with in W. Province, sample withdrawing from</td>
<td>NA Interview</td>
</tr>
<tr>
<td>Mother-to-child transmission rate</td>
<td>% of population adopted HIV-prevention methods</td>
<td>M of H Districts</td>
<td>Desk Research Survey</td>
<td>NA Purposive</td>
<td>NA Interview</td>
<td>Trend Analysis</td>
<td></td>
</tr>
<tr>
<td>% of youth, women, girls and men having used HIV-prevention services</td>
<td>DHS Evaluation</td>
<td>Desk Research Purposive sample survey</td>
<td>NA 100% sample (5) Districts UNFPA works with in W. Province, sample withdrawing from</td>
<td>NA Interview</td>
<td>Trend Analysis</td>
<td></td>
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</tr>
<tr>
<td>HIV Response Plans and Coordination Mechanisms Established at National and Decentralised Levels</td>
<td>Is there an HIV response plan and coordination mechanisms in place at national and local levels?</td>
<td>Number of sectoral, District and CSO action plans in line with EDPRS/NSP implemented and monitored</td>
<td>CNLS Annual Reports</td>
<td>Desk Research</td>
<td>NA</td>
<td>Interview</td>
<td>Trend Analysis</td>
</tr>
<tr>
<td>National Policies and Strategies are Reviewed Based on Evidence from M&amp;E and International Guidance are Implemented</td>
<td>Are national policies and strategies reviewed based on the evidence from M&amp;E and international guidance?</td>
<td>Number of Policies and Strategies revised and implemented</td>
<td>CNLS Annual Reports/TRA C-Net</td>
<td>Desk Research</td>
<td>NA</td>
<td>Interview</td>
<td>Trend Analysis</td>
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<tr>
<td>M&amp;E system operational at national and local level</td>
<td>CNLS Annual Reports/TRA C-Net Evaluation</td>
<td>Desk Research Purposive sample survey</td>
<td>NA</td>
<td>Interview</td>
<td>100% sample (5) Districts UNFPA works with in W. Province</td>
<td>Interview</td>
<td>Trend Analysis</td>
</tr>
<tr>
<td>Has the national partnership on HIV with public institutions, Civil Society, Private Sector and Donors been strengthened?</td>
<td>Frequency of Partnership Forums Organised and % of Partners Represented</td>
<td>Ministry of Health Key Informant Interview</td>
<td>NA</td>
<td>Interview</td>
<td></td>
<td></td>
<td>Trend analysis</td>
</tr>
<tr>
<td>Number of Action Plans Addressing Cross-Border and Sub-regional issues implemented and monitored</td>
<td>Ministry of Health Key Informant Interview</td>
<td>NA</td>
<td>Interview</td>
<td>Interview</td>
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<td>Trend analysis</td>
</tr>
<tr>
<td>Has the coordination and management of the UN support to the National HIV Response improved?</td>
<td>Joint UN Team on HIV Fully Operational</td>
<td>UNFPA Interview with Deputy Resident</td>
<td>NA</td>
<td>Interview</td>
<td></td>
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<td>Verification in Place</td>
</tr>
<tr>
<td>No of Youth Friendly Service Centres for Youth</td>
<td>MIJESPOC evaluation</td>
<td>Key Informant Interview Purposive sample survey</td>
<td>NA</td>
<td>Interview</td>
<td>100% sample (5) Districts UNFPA works with in W. Province, sample withdrawing from</td>
<td>Interview</td>
<td>Trend Analysis</td>
</tr>
<tr>
<td>Number of out of school youth that attend youth-friendly service centres</td>
<td>Evaluation Purposive sample survey</td>
<td>100% sample (5) Districts UNFPA works with in W. Province, sample withdrawing from</td>
<td>Interview</td>
<td>Interview</td>
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<td>Trend Analysis</td>
</tr>
<tr>
<td>Has access to comprehensive packages of prevention services for high risk groups increased?</td>
<td>% females 15-24 and males 15-24 knowledgeable about where to obtain condoms</td>
<td>DHS Desk Research</td>
<td>NA</td>
<td>NA</td>
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<td>Trend Analysis</td>
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<tr>
<td>Increased access to male and female condoms and new HIV prevention technologies</td>
<td>Has access to male and female condoms and new HIV prevention technologies increased.</td>
<td>Number of male condoms distributed</td>
<td>CNLS Reports</td>
<td>Desk Research</td>
<td>NA</td>
<td>NA</td>
<td>Trend Analysis</td>
</tr>
<tr>
<td>Prevention of HIV Protective behaviours adopted and effective preventive services utilized by high risk population</td>
<td>Has there been an increase in the adoption of HIV prevention strategies amongst high risk groups? Has the institutional and technological capacity of all sectors to promote HIV prevention strategies been increased?</td>
<td>% of leaders and stakeholders involved in campaign for enabling environment for HIV prevention and stigma mitigation</td>
<td>MIJESPOC</td>
<td>Stake holder interview</td>
<td>NA</td>
<td>Interview</td>
<td>Trend analysis</td>
</tr>
<tr>
<td>Capacity of Health Service to provide quality comprehensive, integrated, family and community centred HIV Prevention Services</td>
<td>Has the capacity of the health service to provide quality comprehensive, integrated, family and community centred HIV prevention services been increased?</td>
<td>% HF providing family PMTCT</td>
<td>TRAC+/ M of H</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>Trend analysis</td>
</tr>
<tr>
<td>Vulnerable groups and populations at risk of exposure to HIV have increased access to a comprehensive package of HIV prevention services and appropriate commodities</td>
<td>Has the high risk population had increased access to a comprehensive package of HIV prevention services and appropriate commodities?</td>
<td>Number of population at higher risk of exposure – youth, women, sex workers, inter country transporters, refugees and returnees with access to comprehensive package</td>
<td>CNLS/ Annual Reports MoH</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>Trend analysis</td>
</tr>
<tr>
<td>Access to male and female condoms and new HIV preventive technologies and approaches increased</td>
<td>Has access to male and female condoms and new HIV preventive technologies and approaches increased?</td>
<td>Number of male and female condoms distributed.</td>
<td>CNLS/ Annual Reports MoH</td>
<td>NA</td>
<td>NA</td>
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<tr>
<td>All public and Private Institutions Apply Gender Equality Principles and Standards in their Performance, Practices and Behaviour</td>
<td>Are all public institutions applying gender equity principles and standards in their performance, practices and behaviour?</td>
<td>Number of public and private institutions applying 30% quota</td>
<td>Ministry of Gender</td>
<td>Key Informant Interview</td>
<td>NA</td>
<td>Interview</td>
<td>Trend Analysis</td>
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<td></td>
<td>Number of Institutions with Transparent non-discriminatory promotion procedures</td>
<td>GMO</td>
<td>Key Informant Interview</td>
<td>NA</td>
<td>Interview</td>
<td>Trend Analysis</td>
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<td>Number of Development Partners with Gender focal points and equipped with gender planning tools</td>
<td>Ministry of Gender</td>
<td>Key Informant Interview</td>
<td>NA</td>
<td>Interview</td>
<td>Trend Analysis</td>
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<tr>
<td></td>
<td>Number of gender sensitive policies and programmes in sexual and RH and in PD approved</td>
<td>Ministry of Finance – Gender responsive budgeting unit,</td>
<td>Key Informant Interview</td>
<td>NA</td>
<td>Interview</td>
<td>Trend Analysis</td>
<td></td>
</tr>
</tbody>
</table>
### Annex 4: National Indicators UNFPA 6th Country Programme supports

<table>
<thead>
<tr>
<th>Indicator</th>
<th>MDGs</th>
<th>2000</th>
<th>EDRPS Baseline</th>
<th>EDRPS Target</th>
<th>Latest National Data Available</th>
<th>Date and source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Share of population living in poverty (%)</td>
<td>1</td>
<td>60.4</td>
<td>56.9</td>
<td>40.0</td>
<td></td>
<td>2006 Household Survey</td>
</tr>
<tr>
<td>Share of population living in extreme poverty (%)</td>
<td>1</td>
<td></td>
<td>36.9</td>
<td>24.0</td>
<td></td>
<td>2006 household survey</td>
</tr>
<tr>
<td>Poverty incidence amongst female headed households</td>
<td>1, 3</td>
<td></td>
<td>60.0</td>
<td>48.8</td>
<td></td>
<td>2006 household survey</td>
</tr>
<tr>
<td>Infant Mortality Rate (IMR) (per 1,000 live births)</td>
<td>4</td>
<td>107.0</td>
<td>86.0</td>
<td>70.0</td>
<td></td>
<td>DHS</td>
</tr>
<tr>
<td>IMR in bottom wealth quintile</td>
<td>4</td>
<td></td>
<td>114.0</td>
<td>99.0</td>
<td></td>
<td>DHS</td>
</tr>
<tr>
<td>Maternal Mortality Rate (MMR)</td>
<td>5</td>
<td>1071.0</td>
<td>750.0</td>
<td>600.0</td>
<td>200.0</td>
<td>DHS</td>
</tr>
<tr>
<td>Total fertility rate (TFR)</td>
<td>5</td>
<td></td>
<td>6.1</td>
<td>4.5</td>
<td>4.9</td>
<td>DHS</td>
</tr>
<tr>
<td>HIV incidence (% youth aged 15 to 24 years)</td>
<td>6</td>
<td></td>
<td>1.0</td>
<td>0.5</td>
<td></td>
<td>DHS</td>
</tr>
<tr>
<td>% population expressing satisfaction/confidence in decentralised governance</td>
<td>8</td>
<td>65</td>
<td>65.0</td>
<td>80.0</td>
<td>88.6 (29.7 VS, 40.3 SS, 18.6 MS)</td>
<td>EDRPS M&amp;E</td>
</tr>
<tr>
<td>Primary school completion rate</td>
<td>2</td>
<td>22.0</td>
<td>52.0</td>
<td>125.0</td>
<td>100.0</td>
<td>MINEDUC</td>
</tr>
<tr>
<td>% women aged 15 to 49 years using modern contraception</td>
<td>5</td>
<td>4.0</td>
<td>10.0</td>
<td>70.0</td>
<td>45</td>
<td>DHS</td>
</tr>
<tr>
<td>% women giving birth in health centres</td>
<td>5</td>
<td></td>
<td>28.2</td>
<td>75.0</td>
<td>67</td>
<td>DHS 2010</td>
</tr>
<tr>
<td>% of population living within 5 kms of a functioning health centre</td>
<td>4, 5, 6</td>
<td>58</td>
<td>70.0</td>
<td></td>
<td></td>
<td>DHS</td>
</tr>
<tr>
<td>% population covered by health insurance</td>
<td>4, 5, 6</td>
<td>70</td>
<td>95.0</td>
<td></td>
<td></td>
<td>HMIS</td>
</tr>
</tbody>
</table>

Sources: Vision 2020, 2000; EDRPS, 2007; IDHS, 2007/8; DHS, 2010
## Annex 5: Indicators UNFPA Contributes towards at District or National level as defined in UNDAF

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline 2006</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation in democratic governance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of districts with youth representatives serving on Community Development Committees (CDCs)</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>No. of districts with functional children’s committees</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>% of women in decision making positions both at central and local levels</td>
<td>Mayors 6.6%</td>
<td></td>
</tr>
<tr>
<td>Gender equality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of development partners with gender focal points trained and equipped for national women’s organizations</td>
<td>Exist, but not trained</td>
<td></td>
</tr>
<tr>
<td>% of women accessing credit in banking and non-banking financial institutions</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td>% of NIS needs covered in terms of adequate equipment for data processing and management</td>
<td>80.0%</td>
<td></td>
</tr>
<tr>
<td>No. of staff trained in data collection, processing and dissemination</td>
<td>100 NIS, District and Ministry staff</td>
<td></td>
</tr>
<tr>
<td>Health, Population, HIV and Nutrition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of Youth Friendly Services for HIV</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>No. of HIV risk groups with access to comprehensive package of HIV prevention services (information, education &amp; communication; post exposure prophylaxis; sexual and reproductive health, management of sexually transmitted infections and voluntary counselling and testing for HIV)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>No. of male condoms used</td>
<td>1.7 million</td>
<td></td>
</tr>
<tr>
<td>Access to new HIV prevention technologies and approaches</td>
<td>Male circumcision No</td>
<td>Microbicicides No</td>
</tr>
<tr>
<td>Strengthened institutional, technical and operational capacities or organizations of youth, women, people living with HIV, and local NGOs to mobilise for, stimulate and promote social changes for prevention of HIV</td>
<td>Some</td>
<td></td>
</tr>
<tr>
<td>National policies, strategies and standards for health developed and implemented</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>% of health facilities providing a comprehensive care package</td>
<td>45.0%</td>
<td></td>
</tr>
<tr>
<td>% of Umudugudu with trained community health workers</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of new outcomes based curricula developed</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Indicator</td>
<td>Status</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-------------------------------</td>
<td></td>
</tr>
<tr>
<td>Pupil/textbook ratio in primary and TC for core subjects</td>
<td>1:4 in 2001/2</td>
<td></td>
</tr>
<tr>
<td>No. of teachers (male and female) trained on child centred methodologies</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td>No. of teacher modules on child centred methodologies</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Education NGO forum and network in place</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>No. of NGOs and Faith based organizations in the education sector</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td>% of District Development Plans (for school planning) based on population projections</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td>No. of Districts that achieve targets in District performance contracts (for school planning)</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td>Social protection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Emergency Package available for appropriate and rapid response</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Sources: *United Nations Development Assistance Programme Rwanda. UNDAF 2008-2012, Rwanda, UN Rwanda, 28 March 2007*
Annex 6: Data collection tools for partners and key informants

Information collected from UNFPA, other UN Agencies, Ministries, District Officials, NGOs and other agencies. The methods used included interviews, FGDs, data collection, review of web sites. M&E Monitoring and evaluation data and evaluation reports were also consulted.

<table>
<thead>
<tr>
<th>Agency</th>
<th>Information to be collected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UNFPA Programmes Officers</strong></td>
<td>GBV programme based on Mapping Study, relationship with media, interagency working, working with government, commitment from government, shared vision with government, understanding of responsibilities. What are the barriers? How do you work with the ministries? How do you work with the districts? How does the M of LG fit in? What about the other UN agencies and other ODA’s? How do you work with NGOs, FBOs and CBOs involved in delivering projects related UNFPA programmes? How do the UNFPA programmes fit with government priorities? How has the provision of secondary posts for FP been progressed? How many FBHF have a secondary post positioned by it? Numbers for each year 2007, 2008, 2009, 2010. Has the government developed a package of defined needs for youth? Has the joint youth strategy been developed? Is there sufficient segmentation of youth by gender and ages etc? Is there any issue re adolescence? What about the definition of youth? Study of integration of FP with HIV services? Progress re civil registration system Use made of information from GBV mapping study and condom needs assessment Regular field visits monitoring plan? Do you have on? If no why not. If yes who makes the field visits, what is the purpose etc. What has gone well, been successful in the 6th Programme? What has gone less well /been less successful? What enables /facilities success? What are the barriers? What can be done to overcome them? Staff development and capacity building, staff development plan, needs assessment, outstanding needs? How sustainable is the programme? What can be scaled up? How strong is the country ownership? Priorities for 7th Programme? What should be in the 7th Programme? Why? How do these fit with the government’s priorities? Do you think that the next EDPRS will have the same priorities as the present one?</td>
</tr>
<tr>
<td><strong>UNFPA Deputy Representative</strong></td>
<td>Delivering as One initiative, understanding of responsibilities, mobilisation funds to meet shortfalls/resource gaps, harmonisation of reporting and accountability systems with UN and government etc. Shared vision. Who is in the driving seat? Communications with government? How exactly do you work with government? What is the role of UNFPA? What are the barriers to working with the government? Responsibility to government? Responsibility to UN Resident in Rwanda? Responsibility to HO? Reporting arrangements etc. Paris and Accra, leverage of resources, how working at CO? Staff development training plan, staff development delivered, needs assessment? Sustainability of programme Priorities for 7th Programme? Involvement in review of EDPRS 2007-2012?</td>
</tr>
<tr>
<td><strong>UNFPA Operations Manager</strong></td>
<td>Funding and budget, mobilisation of resources, impact (if any) of world economic downturn, absorptive capacity of government? Funding for RHCS?</td>
</tr>
<tr>
<td><strong>Office of UN Resident</strong></td>
<td>One fund – impact on programming, impact on results. What constraints experienced and how overcome, lessons learnt Innovations Impact on resources and rising funds Changes recommended Evaluation of performance of UNFPA Priorities UNFPA 7th CP</td>
</tr>
<tr>
<td><strong>UNAIDs</strong></td>
<td>One Fund Working with UNFPA Evaluation of performance UNFPA Relevance UNFPA programme Priorities 7th CP</td>
</tr>
<tr>
<td>Agency</td>
<td>Information to be collected</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>M of Youth</td>
<td>Working with UNFPA, shared vision and policies and priorities, who in the driving seat. Communication with UNFPA? Has the government developed a package of defined needs for youth? Has the joint youth strategy been developed? Are the needs of different categories of youth adequately taken account of (gender, urban/rural, poor/non poor, age groups)? Is there an issue of adolescence? What is a youth friendly centre? When were they first introduced? Are they in a policy? What are the objectives of them? Has there been an independent evaluation of them/is one planned? Youth Friendly Services, M&amp;E, data on numbers etc. 2007 Gender focal point, trained and equipped with gender planning tools Priorities for UNFPA 7th Programme¿2010 Review of EDPRS2007-12 and priorities in next EDPRS? Sustainability: Scaling up? Priorities for UNFPA 7th CP? Evaluate working with UNFPA?</td>
</tr>
<tr>
<td>M o E</td>
<td>Gender sensitive RG curriculum in secondary schools – progress? % of secondary schools 2007, 08,09, 10 Target for 2011 Condoms in schools? Sustainability Gender focal point, trained and equipped with gender planning tools Evaluate working with UNFPA? Priorities 7th Programme</td>
</tr>
<tr>
<td>M of Health</td>
<td>Working with UNFPA, shared vision and policies and priorities, who in the driving seat? FP Policy? Evaluation of old one? New one being prepared? FBHCs? Posts by FBHCs- how far progressed? Curriculum development for midwives? Progress? Where are you with the White Ribbon Alliance strategic plan: Where are you with the Campaign on Accelerated Reduction of Maternal Mortality in Africa? What is happening re the Rapid SMS? Is it being extended beyond the pilot district? Training of Community Health workers to provide modern contraceptives - is this being scaled up? How many trained CHWs are there now? How many districts are they working in? What is happening with the fistula care programme? Maternal death audits? What is happening? How will it help reduce maternal mortality rate? Condom mapping study – how influenced implementation of policy etc. ? Comprehensive condom programme? Funding and supply of RH Commodities? Sex workers and other high risk populations, targeting, knowledge of numbers etc.? Integration FP needs of HIV+ pregnant women into service? Training rural health workers – numbers etc. GBV included in curriculum for pre- and post-training health care workers TRACnet data, CNLSnet, Annual HIV/AIDS M &amp; E reports 2007-2010. Behaviour surveillance Studies – for all years from 2006 available HIMS etc - % pregnant women having HIV test, % of HIV+ pregnant women having ARs (61% 2007, 74% 2007) Mid Term Review HSSP II August 2011 Working of health SWAP. Gender focal point, trained and equipped with gender planning tools Sustainability? Scaling up? Review of EDPRS2007-12 and priorities in next EDPRS? Priorities for UNFPA 7th CP? Evaluate working with UNFPA?</td>
</tr>
<tr>
<td>NISR</td>
<td>Civil Registration, IMIS GBV data Anticipated by 2013? Gender focal point, trained and equipped with gender planning tools Sustainability? Priorities for UNFPA 7th Programme Evaluate working with UNFPA?</td>
</tr>
<tr>
<td>Women</td>
<td>Mapping gender discriminatory legislation</td>
</tr>
<tr>
<td>Agency</td>
<td>Information to be collected</td>
</tr>
<tr>
<td>------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Parliamentarians Forum | Relevance UNFPA CP  
Evaluate working with UNFPA?  
Priorities 7th CP                                                  |
| Parliamentary Forum on Population | Evaluate working with UNFPA?  
Relevance UNFPA CP  
Priorities 7th CP                                                 |
| HIV/AIDS Officer RALGAs | Information on integrated packages of delivery                                              |
| M of LG                | Role re delivery of UNFPA programmes (RH, HIV/AIDS, Youth Friendly Centres etc.  
How do the responsible ministries work with M of LG?  
How are targets in District Performance Contracts monitored for alignment with other ministries?  
District Performance Contracts M + E for 2007, 08, 09, 10. District Annual work  
Umudugudu programme – economically empower women including sex workers  
Gender focal point trained and equipped with gender planning tools  
Priorities for 7th CP. |
| District Officials     | Working with NGOs, CBOs etc, working relationship, delivery, and adequacy of funding, commitment.  
Is there capacity at focal level to deliver youth friendly centres, FP and maternal health care, education in schools on population, RH and HIV/AIDS Capacity to collect and use in planning relevant statistical data.  
Barriers to programme delivery and how they can be overcome.  
FBOs and FP and advice on prevention HIV? Secondary posts next to FBHSPs? Supply RH contraceptives and other commodities?  
Funding, adequacy resources etc.  
HIV/AIDS data collection and M&E , training in M&E  
Do the health centres/hospitals in the district carry out material deaths audits?  
Civil registration  
Youth Friendly Services  
Education  
Data training  
Gender Focal Point, trained and equipped with gender planning tools |
| Hagaruka               | Women, socio-legal assistance                                                                  |
| Imbuto Foundation      | HIV/AIDS, education, socio-economic development.                                               |
| One Stop shop          | How effective, number of referrals/reports 2007, 2008, 2009, 2010                           |
| Agaseko Project        |                                                                                              |