

Evaluation of UNFPA's Country Programme 3 (CP3) in Afghanistan 2010 – 2013

August to October 2013

**FINAL
EVALUATION REPORT**

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Acronyms

AAAD	Agency for Assistance and Development of Afghanistan
AFGA	Afghan Family Guidance Association
AIHRC	Afghanistan Independent Human Rights Commission
AMA	Afghanistan Midwife Association
ANDMA	Afghanistan National Disaster Management Agency
ANDS	Afghanistan National Development Strategy
ANYP	Afghanistan National Youth Policy
APRO	Asia and Pacific Regional Office (UNFPA)
ASRH	Adolescent Sexual and Reproductive Health
AWP	Annual Work Plan
BPHS	Basic Package for Health Services
CAP	Consolidated Appeal Process
CCA	Common Country Assessment
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CERF	Central Emergency Response Funds
CME	Community Midwifery Education
CMW	Community Midwife
CO	Country Office
COAR	Country Office Annual Report
CP2	Second Country Programme
CP3	Third Country Programme
CPAP	Country Programme Action Plan
CPDS	Coordinated Procurement and Distribution System
CPR	Contraceptive Prevalence Rate
CSO	Central Statistics Organization
DFID	UK Department for International Development
DMoYA	Deputy Ministry of Youth Affairs
EMOC	Emergency Obstetric Care
EPHS	Essential Package of Hospital Services
EU	European Union
FGD	Focus Group Discussion
FHH	Family Health House
FHH+MST	Family Health House Plus Mobile Support Team
FP	Family Planning
GBV	Gender-Based Violence
GIRoA	Government of the Islamic Republic of Afghanistan
HMIS	Health Management Information System
HR	Human Resources
HSSP	Health Services Support Program
ICM	International Confederation of Midwives

ICPD	International Conference on Population and Development
ICRC	International Committee of the Red Cross
IMCI	Integrated Management of Childhood Illnesses
IP	Implementing Partner
ISAF	International Security Assistance Forces
IUD	Intrauterine device
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MHT	Mobile Health Team
MICS	Multi Indicator Cluster Survey
MISP	Minimum Initial Service Package
MMH	Malalai Maternity Hospital
MMR	Maternal Mortality Rate
MoE	Ministry of Education
MoF	Ministry of Finance
MoHRA	Ministry of Hajj and Religious Affairs
MoI	Ministry of Interior
MoPH	Ministry of Public Health
MoU	Memorandum of Understanding
MoWA	Ministry of Women's Affairs
MTR	Mid-Term Review
NAPWA	National Action Plan for Women
NCMA	Nursing and Midwifery Council of Afghanistan
NDF	National Development Framework
NDMP	National Disaster Management Plan
NGO	Non-governmental Organisation
NRVA	National Risk and Vulnerability Assessment
NYJP	National Youth Joint Programme
OAM	Organization of Afghan Midwives
OF	Obstetric Fistula
PDS	Population Development Strategies
PHD	Provincial Health Director
PRSP	Poverty Reduction Strategy Paper
PSA	Population Situation Analysis
PTSD	Post Traumatic Stress Disorder
RBM	Results Based Management
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
SDES	Socio Demographic and Economic Survey
SMI	Safe Motherhood Initiative
SPS	Standardising Pharmaceutical Systems
SWAP	Sector Wide Approach
TA	Technical Assistance

TOT	Training of Trainers
UNAMA	United Nations Assistance Mission to Afghanistan
UNCT	UN Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHABITAT	United Nations Human Settlements Programme
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women (now UN Women)
USAID	United States Agency for International Development
VAW	Violence Against Women
WHO	World Health Organisation
YAP	Youth Advisory Panel
YHL	Youth Health Line
YIC	Youth Information Centre

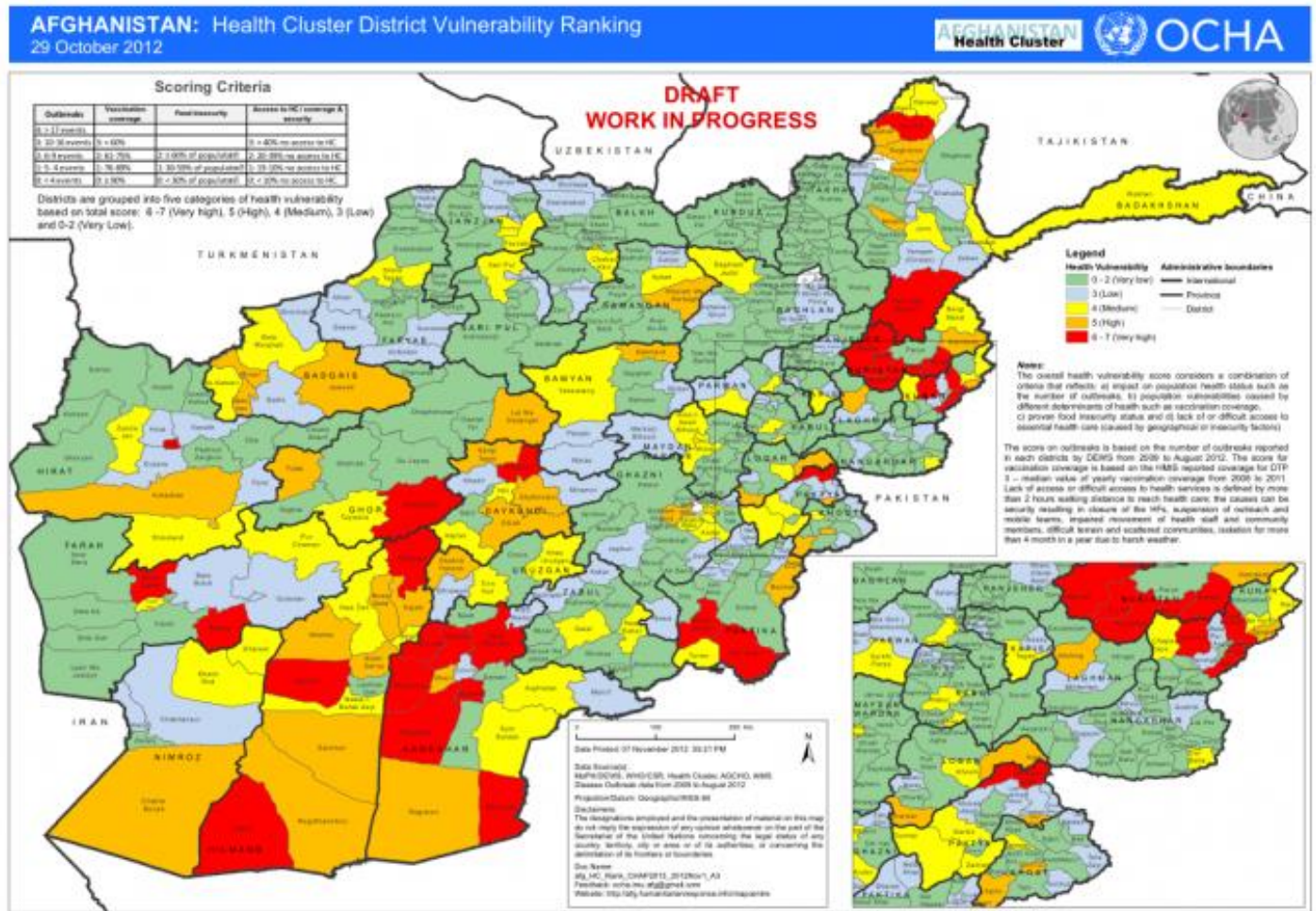
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Map of Afghanistan and Key Facts



Key Facts and Figures – Islamic Republic of Afghanistan¹

Land

- Southern Asia, north and west of Pakistan, east of Iran
- 652,230 square km
- Landlocked, mostly rugged mountains with plains in the north and southwest

People

- 28 to 28.5 million (2012, CSO and UN Common Country Assessment)
- More than 60% aged 20 or less
- Urban population is approximately 21.5%; rate of urbanization 4.4%

Government

- Islamic Republic, 34 provinces

¹ Compiled from: Executive Summary: What does the population of Afghanistan look like in 2013? (CSO and UNFPA for the UN Common Country Assessment); CIA World Factbook, UNDP Website; UNICEF Multiple Indicator Cluster Survey4 (MICS4), 2011.

- Political reconstruction - Bonn Conference in 2001, elections in 2004, 2009
- 25% of seats held by women in national Parliament

Economy

- \$1,100 GDP per capita; Global rank of 216 (2012); 36% living below the poverty line
- 10.2% GDP growth rate (2012)
- Agriculture (20%); Industry (25.6%); Services (54.4%)

Social Indicators

- Human Development Index Ranking: 175 (UNDP 2013)
- 35% unemployment rate (2008)
- Life expectancy at birth: 50 years, Male: 48.81; Female: 51.47 (2013 estimate)
- Maternal mortality ratio: 450 deaths of women per 100,000 live births
- Adult literacy rate (% aged 15 and above male and females): 28.1%
- Infant mortality rate: 74 deaths/1,000 live births (2011)
- Births attended by skilled birth attendants: 39%
- Fertility rate: average of 5.54 children born per woman (2013 estimate).
- Adolescent fertility rates: 90/1,000 women aged 15 to 19
- Contraceptive Prevalence Rate (CPR): 21.8% (2010)
- Unmet need for Family Planning: unknown but estimated at 80%
- HIV Prevalence Rate amongst adult 15-49 years: 0.01% (2001 estimate)

MDGs - Progress to Goals by 2020 (2010 update)

MDG 1 - Eradicate extreme poverty and hunger: Poverty gap ratio = 8% aiming for 5.13%; Underweight children under 5 years of age: 39% aiming for 15% (2015 goal)

MDG 2 – Achieve universal primary education: Net enrollment in primary education = 71% aiming for 100%; Literacy rate of 15-24 year olds = 39% aiming for 100%

MDG 3 – Promote Gender Equality and Empower Women: Ratio of girls to boys in primary education = 66% aiming for 100% (2015); Ratio of female to male government employees = 31% aiming for 100%; Proportion of seats held by women in representative bodies = 21.7% aiming for 30%

MDG 4 – Reduce Child Mortality: Under 5 mortality rate (per 1000 live births) = 161 aiming for 76

MDG 5 – Improve Maternal Health: Proportion of women receiving ante-natal care = 52.9% surpassing 50%

MDG 6 – Combat HIV/AIDS Malaria and Other Diseases: Population in malaria risk areas using preventive measures = 26.7% aiming for 95%

MDG 7 – Ensure Environmental Sustainability: Proportion of the population with sustainable access to improved water sources = 27.2% aiming for 61.5%

MDG 8 – Global Partnership for Development: Proportion of population with access to affordable essential drugs = 75% compared to 100%

Enhance Security - Citizen's confidence in police's ability to provide security = 70.8% (2008) aiming for 100%

Executive Summary

The Government of the Islamic Republic of Afghanistan (GoIRA) and development partners face significant challenges with ongoing security threats, weak governance capacity, and urgency to improve human development indicators. Afghanistan's maternal mortality ratio is 327 deaths/100,000 live births, among the highest in the world. The infant mortality rate is among the highest globally at 79 deaths/1,000 live births.² The fertility rate in Afghanistan is ranked #8 in the world, with the average of 5.54 children born per woman (2013 estimate).

UNFPA and partners in the GoIRA, particularly the Ministry of Public Health (MoPH), the Central Statistics Organization (CSO), the Deputy Ministry of Youth Affairs (DMoYA), the Ministry of the Interior, the Ministry of Women's Affairs (MOWA) and the Afghanistan National Disaster Management Agency (ANDMA), have collaborated on Country Programme 3 (CP3, 2010-2014). The CP3 outcomes are: a) utilization of RH information and increased family planning; b) young people adopt healthy lifestyles; c) increased utilization of socio-demographic data, d) prioritization of needs of young people and women's rights; and, e) environment conducive to eliminating gender based violence.

Through commissioning an independent evaluation of CP3, UNFPA is contributing to the elaboration of the Country Programme 4 (CP4). The major purposes of the evaluation are to assess progress in achieving the approved results, to provide insight into management and sector strategies, to assess whether funds were utilized efficiently, and, to identify lessons and good practices as key inputs to strengthen development of the CP4.

The criteria of relevance, effectiveness, efficiency, sustainability, management and strategic positioning were applied to UNFPA's programmatic areas: Reproductive Health (RH), Population and Development (PD) and Gender Equality (GE). Data were obtained from interviews with stakeholders, two participatory dialog workshops, secondary sources, and observations during a field visit. Quantitative data were consulted to determine whether CP3 targets were met and quantitative data supported the analysis. Data collection and analysis took place from August to October 2013.

Findings and Conclusions

The key findings and conclusions are organized by evaluation criteria and cross cutting issues.

Relevance

UNFPA's support to Afghanistan has been planned in alignment to the Afghanistan National Development Strategy (ANDS), the Millennium Development Goals (MDG) Strategy, the UN Development Assistance Framework (UNDAF) and the International Conference on Population and Development (ICPD) among others, and addresses some of the country's most pressing health and social development problems. The overall relevance is weakened by **challenges posed by insecurity and in accessing remote communities** which have required continuous adjustment of strategies and approaches.

UNFPA's **collaboration with the MoPH for RH** continues to contribute toward achieving MDGs 4 and 5. The response appropriately addressed cultural challenges through advocacy with Religious Leaders, male involvement, and expanding strategies to address women's health issues and choices for family planning (FP). **Raising the capacity of midwives** through strengthening the Afghan Midwife Association (AMA), creating a council as well as establishing formal higher education is highly relevant to raising the quality of RH services. Technical support for RH Commodity Security faces challenges due to **lack of transfer of procurement responsibility from major donors**.

The model Family Health Houses plus Mobile Support Teams (FHH+MST) working in tandem with Community Midwifery Education (CME) are appropriate to serve remote geographic areas and **require sustainable adoption by the Basic Package of Health Services (BPHS)**; inability of women to meet the CME education requirements leave some vulnerable communities without sufficient coverage.

² Afghanistan Mortality Study, 2010.

Support for **development of the Afghanistan National Youth Policy (ANYP)** was timely and relevant, however, Cabinet approval and use of the ANYP remain to be implemented and require enhanced DMOYA capacity. The UNFPA's global experience in Adolescent and Reproductive Health (ASRH) and the well documented youth bulge in Afghanistan should have promoted stronger focus on youth-related activities as per the CP3 Outcomes. The activities undertaken on behalf of youth lacked a cohesive strategy and continuity.

Afghanistan is extremely vulnerable to disasters and emergencies and **UNFPA's humanitarian assistance (HA) is directly linked to outcomes in the ANDs and the UNDAF**. Funds for HA gain visibility for UNFPA while strengthening ANDMA and need to be less piecemeal and tied to a cohesive strategy for disaster risk reduction. Relevance has been somewhat adversely affected because the National Disaster Management Plan has not effectively integrated measures to address RH and Gender Based Violence (GBV) in emergencies.

UNFPA's **support to CSO's socio-demographic and economic survey (SDES)** is well aligned with the country's need for population data; CSO capacity can be further strengthened through linking motivational strategies to capacity development plans. Relevance has been weakened by debates over data collection coverage in the Bamiyan SDES, the use by some organizations of their own parallel systems and need to monitor and steer the utilization of data to promote greater satisfaction from users.

UNFPA's focus on gender equality is highly consistent with Afghanistan's policy environment, upholding treaties such as the CEDAW and the Beijing Platform as well as articles of the constitution, the ANDS Gender Equity Cross-cutting Strategy. An assessment helped to form the **country specific health response to the GBV concept model**. The police sector response project received acknowledgement in UN Secretary General Report for Afghanistan of 2010 as being of crucial importance in line with the transition process.

Effectiveness

UNFPA's technical support for MoPH capacity development has promoted effective stewardship but stronger information, education and communications are needed to increase the demand for RH services. UNFPA's technical assistance is effectively elevating the standards and practice of midwifery, however, the NCMA needs support for establishing a physical presence and operations. **Training of midwives** since 2005 by the MoPH, supported by UNFPA among others, is widely believed to have contributed to the drop in maternal mortality measured in 2010. **Fistula repair** has been successful with over 60 women but approximately 15% of complicated cases are turned away due to lack of necessary surgical skills.

The MoPH with UNFPA support has developed **82 functional Family Health Houses (FHH) and 9 Mobile Support Teams (MST)** in areas not served by the Basic Package of Health Services (BPHS) in 4 of the 34 provinces: Faryab, Daikundi and Bamiyan, and soon to be established in Herat. UNFPA also supports 4 Mobile Health Teams (MHT). The model effectively uses the community as the key to selection of the CMW and for sharing in funding, building and supporting the FHH; performance has received positive reviews from communities and government. **Constraints to operations** include potentially hazardous travel in insecure and remote mountainous areas and harsh winter weather, lack of qualified trainers in the provinces, and heavy workloads for CMWs.

Technical assistance for **youth focused activities** had mixed results. The Youth Health Line (YHL) has a heavy call volume but changes in KAP and accessibility to the most vulnerable youth have not been assessed. **Peer support and counseling** may be successful if revitalized as the Youth Information Centers (YIC) and the Youth Advisory Panel (YAP) were not sufficiently youth driven. Teacher training and curriculum development activities were not carried out as planned and talks have now resumed with the Ministry of Education.

Advocacy with parliamentarians to promote PD objectives has thus far produced limited results. The data on **SDES of three provinces** has been effectively collected; promoting usage of the findings and data should be more strategic. Although still limited in coverage, **district disaster preparedness planning exercises** are planned to utilize SDES data - the challenges will be to ensure that GBV and RH are included to build provincial and community capacity. UNFPA has contributed toward the Minimum Initial Service Packages (MISP) through distribution of RH kits and personal dignity supplies. The **MISP training activities** were effectively designed and need to be widely replicated and include follow-up evaluation.

Technical assistance for GE has promoted effective interventions and trained over 3,500 people **playing a prominent role in raising awareness of GBV**. The Family Protection Centres in Kabul and Jalalabad go beyond awareness to actually support GBV victims. Effective police training resulted in expansion to other

provinces. Advocacy efforts, some through the GBV Sub Cluster, utilized a wide range of approaches to awareness raising on GBV and early marriage. More coverage and evidence of effectiveness would enhance the GE outcomes.

For **transversal aspects**, HA has synchronized with RH and PD, however, fragmentation of the youth support theme among programmatic areas has not significantly strengthened the outcomes. Gender Equality needs to be mainstreamed into RH and PD through development of clear strategies, indicators and targets. Unifying themes may be to intensify focus on integrating child marriage and preventing early pregnancy across GE, RH, PD and youth.

Efficiency

Difficulties in disbursement to national implementers has affected quality such as data collection in the SDES. Overall efficiency can be improved by advocacy and **close communication with donors** for reduction of earmarking and more flexibility as well as continuity to achieve Country Programme Action Plan (CPAP) results. **Greater collaboration with other agencies** will close gaps and prevent duplication.

A **loss in momentum to meet ASRH and youth development goals** occurred due to need to close four out of five YIC and difficulties in gathering partner support to promote the teacher training. Approximately 50% of the planned youth budget was not used and actual spending comprises less than 3.5% of the CP3 budget which is not proportional to the strong CPAP focus on youth outcomes.

The **institutional strengthening of CSO** has the potential of developing a national system useful to all stakeholders; lessons learned from the Bamian SDES are being applied to ongoing and future surveys. The **funds (15.5% of the total budget of USD \$ 38.8 million) and staff devoted to GE are not sufficient** to meet the demand for services which are producing significant results.

Sustainability

Sustainability is a major challenge because **GoIRA ownership and leadership in absorbing financial responsibility and executing projects** is generally weak, despite GoIRA goals of administering 50% of programme budgets. Cohesive approaches are needed by all development partners to move capacity to the government and other Afghan stakeholders. Means and evidence of transfers of capacity are not always stipulated in MOUs and contracts – e.g. technical advisors should not be performing their tasks in isolation rather using coaching and mentoring with evaluated results.

As demonstrated through RH and GE activities **targeting of males and religious leaders promote sustainability**. UNFPA successfully advocated for **inclusion of ASRH into the Basic Package of Health Services (BPHS)** and should work toward doing the same for the FHH and GBV. Sustainability may be effectively pursued through the **youth networks and community based organizations**, but the support for their capacity development has so far been limited. For CSO, **investment is needed to expand the pool of well-trained data collectors and analysts**.

Management

UNFPA along with its IPs receives **high marks for technical assistance and cooperation with other organizations**. The partnerships through the IPs have resulted in **good working relationships with provincial stakeholders**. UNFPA participates in a number of coordination mechanisms but greater efforts are needed to work closely with government counterparts, other UN organizations, and donors to address development issues with one voice. Staffing shortages or unfilled positions have weakened **UNFPA's presence in planning forums** and follow-up and consequently UNFPA's influence in promoting the goals of the ICPD.

More **strategic and realistic results based planning** with buy-in from all programme staff and partners is needed to anchor the programme. The CO monitoring functions have suffered from the lack of an M&E specialist for most of the CP3 and the CO has not fully institutionalized results-based management. Data on indicators have not been collected systematically. **A review of operating systems** is important to ensure that they are results rather than activity based as well as development of a performance monitoring system. A **jointly coordinated M&E plan with government and IPs** that designates adequate time and resources to carry out joint M&E functions is vital.

Strategic Positioning

UNFPA has positioned CP3 more strategically than CP2 and needs to ensure that its mandate and **strengths are well represented on the UNCT and throughout the UNDAF** planning process. The GoIRA partners want **greater evidence of UN Delivering As One**, more resources channeled through MoFA, greater use of media, civil society, and community based bottom up planning, stronger investment in women's organizations and women's professional training, and greater sharing of reporting and stronger communications. While the RH, PD and GE strategies are still largely viable, **youth and humanitarian assistance results require greater focus and ensuring that transversal aspects are results-driven**. Successes from the FHH pilot, youth health line, MISP training, and gender awareness raising, among others, should be replicated by UNFPA or other agencies as per their capacity to extend coverage.

Recommendations

The following recommendations are directed to UNFPA to be carried out in cooperation, coordination, collaboration and jointly with GoIRA partners, implementing partners, donors and communities.

Relevance

1. Conduct assessments and surveys to support effective targeting of resources regarding maternal mortality, obstetric fistula, early marriage, the SRH risks, ASRH, unmet needs for FP and reasons, infertility, and user interface and application of CSO data.
2. Strengthen emphasis on joint strategic planning processes for RHCS, Midwifery-led Birthing Centers, inclusion of the FHH+MST in the BPHS strategy, ASRH and youth development, Disaster Risk Reduction and inclusion of RH and GBV in disaster preparedness plans.
3. Strengthen support services of CMWs in FHH through targeting potential CME candidates with literacy training, monitoring the quality of support by the community, and assessing FHH CMW caseloads.

Effectiveness

4. Design behavior change communications (BCC) using multi-media on SRH including family planning in the context of Islam, engaging sensitized Religious Leaders and targeting youth.
5. Increase coverage and improve quality of the services to address Obstetric Fistula by training more dedicated physicians in basic and advanced fistula repair, supplying modern equipment, and replication of the OF wards and surgical facilities to increase coverage in the provinces.
6. Expand effective capacity development and programmatic interventions, following review and evaluation, using UNFPA and/or other sources of funds.
7. Expand the UNFPA Gender Unit mandate to support gender mainstreaming into other programmatic areas and Human Resources; establish targets for recruitment of women professionals and a Gender Roster.

Efficiency

8. Ensure user friendliness for funds - streamline procedures for disbursements and work toward more accurate estimations for budgets to support quality work to reach programme objectives.
9. Negotiate with donors to provide funding that ensures continuity and cohesiveness within provincial strategies to reach CP results; maintain a well-established communications system with donors.

Sustainability

10. Work with the DMoYA, CSO, AMA, Organization of Afghan Midwives (OAM), the Nursing and Midwifery Council of Afghanistan (NCMA) and the MoPH to support their capacity assessment and development/implementation of motivational and capacity building strategies.
11. Evaluate the pilot FHH + MST + CME pilot project including a costed model and advocate among the MoPH and donors for replication to other provinces.

Management

12. Foster internal and external coordination mechanisms by active presence at planning and coordination meetings, recruitment of new GBV Sub Cluster Coordinator, strengthening the formal forum for generating population data led by CSO, and raising awareness of UNFPA's Gender Equality Programme among UN agencies.
13. Conduct an internal human resources assessment to prepare for CP4 and expansion of activities.
14. Develop an M&E Action Plan with GoIRA partners that includes an operating budget to cover M&E database, surveys, and joint field missions; Develop and align M&E systems so they are results based for coherence in the entire programme cycle; Define realistic results, targets and indicators for CP4.

Strategic Positioning

15. Strengthen transversal aspects by creating a higher profile unit for Adolescents and Youth pursuing stronger interventions for youth/gender in less served focus areas, such as prevention of child and forced marriages and adolescent pregnancies, youth drug users and other marginalized youth; integrating ASRH in education and the FHH; and ensuring that transversal aspects are results driven.

Chapter 1 Introduction and Country Context

1.1 Introduction to the Country Programme 3 Evaluation

1.1.1 Purpose and Objectives

Through commissioning an independent evaluation of Country Programme 3 (CP3) for Afghanistan, 2010-2014, UNFPA is contributing to the elaboration of the Country Programme 4 (CP4). Key findings from the evaluation would inform the development of policies and strategies by the UNFPA Country Office (CO) in Afghanistan. The evaluation findings and results provide guidance to the CO in Afghanistan to strengthen planning, management, monitoring and evaluation in the context of results based management.

The major purposes of the evaluation are to assess progress in achieving the approved programme results, to provide insight into programme management and sector strategies, to assess whether funds were utilized efficiently and effectively, and, to identify lessons and best practices. Lessons learned, conclusions and recommendations from the evaluation will be fully utilized as key inputs to strengthen the development of the CP4.

The specific objectives of the independent evaluation of the UNFPA Country Programme (CP3) for Afghanistan are:

- to provide the UNFPA Country Office in Afghanistan, national programme stakeholders, the UNFPA regional office, UNFPA headquarters as well as the wider audience with an independent assessment of the relevance and performance of the CP3;
- to provide an analysis of how UNFPA has positioned itself to add value in an evolving national context;
- to draw key lessons from past and current cooperation and provide a set of clear and forward- looking options leading to strategic and actionable recommendations for the next programming cycle.

Through the evaluation process, the evaluation report aims to be useful to UNFPA and its partners and other stakeholders. The key users of the evaluation findings and results include the CO, IPs, government ministries, other UN agencies, donors, development partners and beneficiaries of the current programme cycle and potential partners in the next cycle. The evaluation findings and lessons learned should also be used by planners and decision makers in Government, IPs and donors to further enhance engagement, partnerships and collaboration in relevant areas and national priorities.

1.1.2 Scope of the Evaluation

Coverage, time period, target groups, and programmatic aspects

The evaluation covers the CP3 implementation from January 2010 to September 2013 and applies the criteria of relevance, effectiveness, efficiency, and sustainability. The evaluation assesses the level, nature and quality of programme management, institutional partnerships and governance arrangements within the CO and with implementing partners, government, relevant UN agencies, donors and development partners, among others. In addition the evaluation determines the internal and external strategic positioning of UNFPA Afghanistan's programmes and interventions.

In order to make a realistic assessment of the net gains of activity implementation, the evaluation examines interventions at national and sub-national levels, particularly of those underserved regions, districts and targeted communities. It covers all aspects of programme delivery in all targeted areas country-wide. The evaluation was able to reach a sample of the target groups to gather lessons and opinions. This includes: nurses and midwives trained, staff in RH clinics and hospitals, women benefitting from RH services, youth benefitting from UNFPA supported programmes, communities benefitting from RH, youth and disaster preparedness planning activities, as well as secondary recipients of capacity development to serve the key population groups: government and NGO staff benefitting from training, technical assistance and other inputs such as staff from relevant ministries, local and provincial authorities, CSO, legal offices and police forces.

The evaluation focuses on three programmatic areas: reproductive health (RH), population and development (PD) and gender equality (GE); and two sub-programmes: youth empowerment and sexual and reproductive health (SRH), and humanitarian assistance.

- Under RH, the evaluation covers maternal health, family planning, reproductive health commodity security, adolescent sexual reproductive health (ASRH), youth friendly services and life skills opportunities, HIV and STI SRH linkages and humanitarian crisis.
- Under ASRH and Youth Development, the evaluation examines the process of supporting development of the National Youth Strategy, implementation of the Youth Health Line and Youth Information Centers, as well as cross programme youth supporting initiatives and advocacy.
- Under Humanitarian Assistance, the evaluation looks at the institutional strengthening to use the Minimum Initial Service Package (MISP) in emergency response and the distribution of Emergency Reproductive Health Kits, as well as the support for district level disaster preparedness planning and training.
- Under PD, in relation to young people and gender issues, the evaluation examines the net gains in the improved availability of quality and credible demographic data at national and sub national levels and its utilization for advocacy, policy formulation, implementation, and monitoring and evaluation. It examines whether capacity of institutions and stakeholders has been strengthened at national and community levels on the utilization of data and statistics.
- Under GE, the evaluation covers participation of women in decision-making relative to healthy families and livelihoods, and relative to preventing, responding and monitoring of gender based violence. The evaluation examines institutional strengthening of the Police Force and the health systems protocol to prevent, respond and monitor gender based violence.

1.1.3 Methodology

The evaluation was carried out by a four women team commencing on August 1 and concluding on October 10, 2013. The in-country data collection from August 28th to September 20 involved extensive consultations with implementing partners (IPs), government, donors, development partners and UN agencies and other relevant stakeholders in Kabul, Afghanistan. The Evaluation Team traveled to Bamiyan Province and visited select projects to ascertain the net gains of these projects/activities and interventions in the quality of life and development outcomes in the communities. Two lessons learned workshops were held in Bamiyan and Kabul and are described below. A survey questionnaire was completed by workshop participants.

Six criteria form the focus of this evaluation with a number of key questions for each criteria. (Please see the TOR in the annexes.)

Relevance. Determine the relevance of the outputs of the current CP3 to regional and national development priorities and strategies, the MDGs, CEDAW, ICRC, the UNDAF, and UNFPA mandate, and rights holders

Effectiveness. Assess the effectiveness of the Country Office activities/interventions during the CP3 country programme cycle in achieving targets

Efficiency. Evaluate the level of efficiency demonstrated during programme implementation in order to attain results identified during the programme cycle

Sustainability. Examine the potential sustainability of results by building local capacity in programme implementation

Quality Management, institutional partnerships and governance arrangement. Determine the level, nature and quality of programme management, institutional partnerships and governance arrangements within the Country Office and with implementing partners, government, relevant UN agencies, donors and development partners and other relevant stakeholders

Strategic Positioning. Determine the internal and external strategic positioning of UNFPA Country Office programmes and interventions.

Evaluation Methods

The CP3 evaluation follows a participatory, gender and culturally sensitive approach through use of mixed methods. The evaluation involved CO staff, beneficiaries, donors, government and implementing partners (IPs) in reflecting on the achievements and challenges as well as strategic planning necessary for the next country programme (CP4). The evaluation corroborated its findings by combining conventional methods of programme evaluation (review of documentation, semi-structured interviewing, and survey questionnaire) with more dynamic and participatory methods (such as workshops, appreciative inquiry, focus groups, and testimonials).

The following six methods of data collection were used.

1. The **review of documentation** provided a solid understanding of the CP3, its implementation, progress and future directions. Key documents included the Country Programme Action Plan (CPAP), the UNDAF 2010-2014, the CP2 Evaluation, the UNFPA Population Situation Report (2013) and annual work plans, financial reports and monitoring reports. More than 50 documents were reviewed.

2. **Semi-structured interviews** were carried out with stakeholders, including Government representatives, donors, NGOs, civil society and beneficiaries, particularly women and youth. Interview guides were developed for each programmatic area and level of management. More than 80 key informants were interviewed.

3. **Testimonials** were gathered on how the programme has made a difference in the lives of participating youth, women and men stakeholders.

4. **Focus Group Discussions** involved key project stakeholders and beneficiaries using topic guides depending on the activities participants were involved in as per the Annual Work Plans. More than 10 focus group discussions took place.

5. **Lessons Learned workshops and round tables** were reflective as well as forward looking exercises to help inform planning for the next CP. The workshops involved stakeholders from Government, UNFPA programme staff, donors, civil society, NGOs and women and men beneficiaries who have an intimate knowledge of the UNFPA Country Programme and some of its activities. (The Bamiyan workshop involved 22 stakeholders with tables for Gender, RH, PD, and Beneficiaries, and the Kabul workshop involved 20 stakeholders with tables for Youth, Gender and two tables for PD). The topics of discussion were as follows:

- Strengths and limitations of the UNFPA Country Programme
- Lessons Learned from past and current UNFPA cooperation and challenges going forward with the UNFPA Country Programme
- Best practices and strategic and actionable recommendations for the next programming cycle
- Sustainability - What is needed to ensure local capacity in programme implementation and long-term viability of the programme?

6. **Survey questionnaire.** In addition to the discussions described above, participants completed ranked inputs and outputs of the programme. (See results of the survey in the annexes.)



Prioritizing workshop findings using dot democracy in the Bamiyan CP3 Workshop

Quality and Standards

The evaluation criteria, questions and process follow the “UNFPA Handbook on How to Design and Conduct a Country Programme Evaluation” (2012) and evaluation ethics determined by the UN Evaluation Group. The evaluation was managed by the UNFPA Afghanistan M&E Advisor as part of an Evaluation Management Group formed to provide guidance to the evaluation process. The Evaluation Team prepared a Design Report at the

start of the evaluation which lays out the interpretation of the Terms of Reference (TOR), and this design was subsequently approved by the Evaluation Management Group.

1.1.4 Evaluation Limitations

The major limitations for the evaluation and the ways in which they were addressed are as follows.

1. **Scope** - UNFPA opted for a “light” and thematic evaluation with a limited number of evaluation days. As such, all programme data was not analyzed for assessment of each project area and it was not possible to sample the project sites to engage with a broad range of beneficiaries. Thus the team focused on the results based management and obtaining data through interviews and by engaging stakeholders in two workshops.
2. **Data limitations** – A number of the CP3 indicators lack baseline data so in some cases outcomes and impacts were difficult to measure. The team collected opinions, testimonies and used a wide range of data to judge results.
3. **Time and security restrictions on provincial visits** – While it was hoped that at least two provinces could be visited, the security, time and logistical constraints were too numerous to implement more than one provincial visit, thus the direct observations of the team in the provinces were limited and extrapolation and triangulation through secondary sources were necessary to form conclusions.
4. **Access to documentation** – Although the CO provided a number of strategic documents as well as selected project documents, the team did not receive the COAR or Office Management Plans from 2011, thus discussion of 2011 results is limited with regard to UNFPA’s global mandates. The evaluation focuses mainly on activities implemented in 2010 and 2012 to the present as well as future strategic directions.

1.2 Country Context

The Afghanistan National Development Strategy (ANDS)³ describes the numerous and complex challenges after nearly three decades of continuous conflict. The country emerged in late 2001 as a truly devastated state with its human, physical and institutional infrastructure destroyed or severely damaged. Further, Afghanistan’s human development indicators indicate serious challenges to development.⁴ The 2013 UNDP Human Development Report ranked Afghanistan at 175 or one of the poorest countries in the world.⁵ The average life expectancy is only 50 years, among the lowest in the world. Afghanistan’s maternal mortality ratio is 450 deaths/100,000 live births (2010), among the highest in the world. The infant mortality rate is among the highest globally at 74 deaths/1,000 live births.⁶ The fertility rate in Afghanistan is ranked #8 in the world, with the average of 5.54 children born per woman (2013 estimate).

In addition to the development issues, the Government of the Islamic Republic of Afghanistan (GoIRA) must deal with continuing and ongoing security threats from extremists and terrorists, weak capacity of governance and corruption, poor environment for private sector investment, the corrosive effects of a large and growing narcotics industry and major human capacity limitations throughout the public and private sectors. Though considerable efforts and resources have been dedicated since 2001, security has deteriorated particularly in cross-border provinces in the South and East. The lack of stability reduces the ability of aid agencies and the Government to operate in many areas and to effectively implement projects and programs. The impact of these limitations typically falls most heavily on the poor and vulnerable. Rebuilding the country will take many years and requires consistent international support. As agreed in the Kabul and Lisbon Conferences of 2010, there will be a gradual transfer of security responsibilities from the UN-mandated International Security Assistance Force (ISAF) to the Afghan authorities during the year 2014.

³ Afghanistan National Development Strategy (ANDS), 2006.

⁴ Compiled from the CIA World Factbook, 2013

⁵ UNDP Human Development Indicators, 2013.

⁶ UNICEF Multiple Indicator Cluster Survey4 (MICS4), 2011.

There are numerous challenges within the above context specific to implementing core development programmes specifically in the areas of human rights and much needed service delivery programs including:⁷

- Disparities of the marginalized and most vulnerable including the poor, youth, and women to have equal access to essential services and information.
- Government, civil society and the private sector's lack of availability of viable data to make critical decisions; e.g. there are no birth or death registries. Most importantly there is a lack of good denominator data which only a good census can offer.
- Inequality of women to access human rights protections, to vital health and education services, and employment.⁸

The evidence basis gathered by UNFPA for the UN Common Country Assessment (CCA) in 2013 indicates the following areas of progress and concern:^{9 10}

Reproductive Health - In March 2003, the Basic Package of Health Services (BPHS) was launched in Afghanistan, aiming at providing national access to healthcare and reducing mortality and morbidity. Although there is a clear focus on reproductive and maternal health within the BPHS guiding principles that has had some positive impact on women's health, maternal health indicators remain substandard as a result of cultural practices and lack of capacity within the health system. It is estimated that the BPHS covers approximately 60% of the population and is not sustainable without external funding.

There is some evidence for a transition to a lower fertility rate however, the risk factors are prevalent (early and late maternal age births and short birth intervals). Maternal mortality has declined in the last ten years, but only 16% of all births can be considered to be relatively 'low risk'. The most common causes of maternal deaths are haemorrhage, obstructed labour and eclampsia. Significant progress has been made in the number of mothers who receive antenatal care which has already exceeded MDG 2020 goals (52.9% compared to 50%), who are attended by qualified skilled birth attendants (SBAs), approximately 39%¹¹, and who seek post-natal care, but the levels by international standards remain very low. The low levels of RH care are closely connected to high prevalence of obstetric fistula, although data are scarce. Use of family planning (FP) is still low; only 20% of married women aged 15-49 years are currently using a modern contraceptive; level of education is an important explanatory variable for modern contraceptive use.

The data gaps in the health sector have been partially addressed through the 2010 Afghanistan Mortality Survey (AMS), and the Multiple Indicator Cluster Survey (MICS), increased monitoring of RH services and a maternal death audit. Unfortunately, no data are available about unmet needs for FP in Afghanistan, which is one of the MDG indicators for MDG 5. There has been no recent Demographic Health Survey (DHS) in Afghanistan which could serve to efficiently collect this information. Preparation of an investment case for health related MDGs has commenced. A working group was established at the MoPH to generate gender disaggregated data through the Health Management Information System (HMIS) and guidelines for data collection on GBV from health facilities were developed. The "*H4 Plus Action Plan on Improving Maternal and Newborn Health in Afghanistan*" is being developed by the H4 global initiative to harmonize actions between the H4 partners (UNAIDS, UNFPA, UNICEF, UN Women, WHO and the World Bank), however, this initiative has not moved forward significantly in Afghanistan.¹² The H4+ now includes other agencies such as USAID, CIDA and the International Confederation of Midwives.

Population and Development – There has been significant progress in expanding the information base through nationally sampled surveys such as the National Risk and Vulnerability Assessment (NRVA), the MICS, the AMS, and others, in the last decade, however, most databases are not an integral part of a national statistical system. Databases managed by each line Ministry vary in terms of capacity, resources, and quality;

⁷ United Nations Population Fund (UNFPA) Population Situational Analysis 2012

⁸ National Gender Strategy, 2012-2016

⁹ UNFPA's Population Situation Analysis, 20 January 2013.

¹⁰ Trend Analysis of Afghanistan Key Health Outcome Metrics - Moving Toward MDG Targets – 2002-2011 – Donor Coordination Meeting, powerpoint presentation prepared by William Brady, M&E Advisor USAID, April 2013

¹¹ UNICEF Multiple Indicator Cluster Survey4 (MICS4), 2011

¹² UNDAF Mid-Term Review, Basic Social Services Narrative

there are inconsistencies in interpretation – due largely, for example to varying design concepts and methodology of data collection.

The country still lacks a functioning population and vital registration system and the availability of disaggregated data and especially geo-referenced data is still limited, however, recent survey data has been successfully compiled for several provinces and districts (in Bamiyan, Daikundi and Ghor). With view to the transition process starting in 2014 it has to receive increasing attention. Strengthening of the normative and coordination role of the Central Statistical Organization (CSO) is in process and should be in line with the development of a national integrated statistical system and but also in coordination with Kabul University, to enhance capacities for in-depth analysis of geo-referenced data, as well as senior analysts at line ministries.

Gender Equality and Women's Empowerment – Government recognition of gender equality and empowerment of women and girls has resulted in reduction in restrictions on access to education, work, and health care. However, the female literacy rate and women's participation in the labour market are weak/lower than men's. Afghanistan has an illiterate adult population of 9.5 million of which 5.5 million are women. (The ratio of female literacy for the age group 15-24 measures progress toward equity in literacy). With regard to MDG2 (universal primary education), the ratio of girls to boys in school shows a decline with the level of education (52% primary to 21% tertiary).¹³ The number of female teachers, however, has reached 30%.

Translating reformed and new policies into practice through legislative and administrative reforms continues to be a struggle. All forms of violence against women are pervasive and impunity of the perpetrators of violence is almost absolute. Initiatives against GBV included community based dispute resolution mechanisms (CDRMs) and shuras, and strengthening police and health sector capacity response to GBV. Gender mainstreaming has not been substantively implemented. Women of disadvantaged social groups still experience multiple discriminations.

Cross cutting populations of concern for RH, PD and GE. Women and girls form a target population as underserved persons. Other groups suffer social differentials, caused by **social identity** (e.g. Kuchi and gypsy ethnicities); **location** (residents of remote and inaccessible areas, residents of insecure areas which are the scenes of active conflict) and **disability**, among others. Migrants from both within and outside the country, such as IDPs and returnees are also vulnerable.

Youth constitute a vulnerable group in Afghanistan due to the “youth bulge” or extreme proportion of the youth population in comparison to other age groups. Research by the World Bank in 2004 suggests that a combination of the country's poor economic performance and the youth bulge could serve to amplify tensions and unrest. On the other hand, the youth bulge also has the potential to produce a demographic dividend to generate strong economic growth, depending on efforts to structure economic development to meet the needs of youth.¹⁴

Youth size and trends in Afghanistan. Roughly 68% of Afghanistan's 26.5m citizens are under 25, with those ages 15-24 accounting for 40% of the total population, according to a 2011 Central Statistics Organisation report, while according to the CIA World Factbook, 42.5% of the population is under the age of 15 and UNDP reports that 68% is under the age of 25. This demographic imbalance may exacerbate the already high unemployment rates and promote disenfranchisement over the lack of educational and employment opportunities. Many youth are involved in family owned poppy farms and in narcotics trafficking and some join insurgency groups for economic opportunities. Only 49% of young males and only 18% of young women 15-24 years of age are literate. Urbanization is on the rise at approximately 4.7% annually, which brings with it risks of increased crime, drugs and gangs among the youth.

Health of Youth. A 2009 UNODC survey found that drug use was prevalent among 8% of the population 15-64 years of age, twice the global average. Poor youth suffer the lack of access to health and reproductive health services as the general population living in poverty and their average life expectancy is less than 50 years. The *Afghanistan Youth Assessment Study* (Samuel Hall, 2013) found that a large proportion of Afghan youth suffer

¹³ Afghanistan MDG 2010 Report

¹⁴ Linda Lavender, “The Youth Bulge in Afghanistan: Challenges and Opportunities”. Civil-Military Fusion Centre, October 2011, pages 1-6.
FINAL - UNFPA Afghanistan Country Programme 3 (CP3) Evaluation – FINAL submitted Dec 29 2013

from untreated mental health issues resulting from trauma and stress relating to conflict, displacement, poverty and continued insecurity. Despite the fact that youth represent 40% of the Afghan population, health services are not targeted at this group. This neglect of youth health is partly a result of lack of data on youth specific health needs but also points to the need for stronger mainstreaming of youth issues in national health strategies and services.¹⁵

Sexual and reproductive health; marriage and adolescent birth rates. There is little data on the sexual and reproductive health (SRH) needs of unmarried youth. Cultural barriers and stigma surrounding sexuality and reproductive health are major challenges to the incorporation of age-appropriate sexuality education in policies and curricula. Young people who are not married generally lack access to SRH information, although this is changing through the RH programmes. Young women and men from rural areas are also disadvantaged in terms of access to health services and health rights. This difference is particularly significant for RH rights.

According to the *Afghanistan Multiple Indicator Cluster Survey (AMICS) 2010/2011*, 15.2 per cent of surveyed women were married before the age of 15, while 46% were married before the age of 18. In Bamiyan, among males aged 20-24 years, those who were married at the time of the survey comprised 29.6 %, while among females in this age group, the corresponding percentage was much higher at 65.3%. At age group 25-29, nine in ten of the women, compared to seven in ten males of the men, were married.¹⁶ Afghanistan's high adolescent birth rate (90/1,000 women aged 15 to 19) poses a major risk to young girls' and women's health. Adolescent birth rates have declined since 1990, however, the median age at first birth is low among Afghan women; among women 25 – 49 years of age, the median age at first birth is 20 years. For young women the risk of maternal death or disability is significantly higher: the proportion of girls between the ages of 10 to 14 that die during pregnancy or childbirth is five times higher than that of women aged 20 to 24, and twice as high as among girls 15 to 19.¹⁷

Disaster Prone and Disaster Affected Populations

Afghanistan represents a complex humanitarian situation where the 'disasters', both natural and man-made, are recurrent, frequent, and longstanding, their spatial configuration changes constantly, and the entire national government has had to be simultaneously re-built.¹⁸ In a crisis or refugee situation, one in five women of childbearing age is likely to be pregnant. Conflicts and natural disasters put these women and their babies at risk because of the sudden loss of medical support, compounded in many cases by trauma, malnutrition or disease, and exposure to violence. In times of upheaval, pregnancy-related deaths and sexual violence increases. Reproductive health services - including prenatal care, assisted delivery, and emergency obstetric care - often become unavailable. Young people become more vulnerable to HIV infection and sexual exploitation. And many women lose access to family planning services, exposing them to unwanted pregnancy in perilous conditions.

The 2012 Consolidated Appeal (CAP) requested US\$ 437 million to meet the needs of more than 600,000 internally displaced persons (IDPs), reflecting an alarming increase in the number of conflict induced IDPs, over 3,000,000 Afghans affected by natural disaster, including 2.8 million affected by recurrent drought, 162,000 projected refugee returnees, 5.4 million conflict-affected people with limited access to basic services, 4.4 million of whom are women and girls.¹⁹ The Afghanistan National Disaster Management Agency (ANDMA) is responsible for the implementation of the National Disaster Management Plan 2010, which offers a basic framework and does not contain RH considerations.

1.2.1 National and International Development Strategies

Strategies relevant to UNFPA's major programmatic areas, Reproductive Health, Population and Development, and Gender Equality are mentioned in this section. The Afghanistan National Development Strategy (ANDS) provides the framework and guidance for implementing all development in the post-conflict Afghanistan by Government, civil society, the international community and all development stakeholders. In addition, the

¹⁵ Afghanistan National Youth Policy, draft, July 2013, page 14.

¹⁶ Afghanistan SDES Bamiyan Final Report 24 April 2013, page 17.

¹⁷ Data secondary sources from the Afghanistan National Youth Policy, draft, July 2013, page 13. (Sources UNFPA, 2012 and 2007)

¹⁸ Draft UN Common Country Assessment (CCA, 2013)

¹⁹ UN, Consolidated Appeal, Mid-Year Review, Afghanistan, 2012.

Government and the international community have entered into a series of agreements concerning the direction of and support for the country's development efforts, including most notably the Bonn Agreement (2002), the commitment to the Millennium Development Goals (MDGs), the Afghanistan Compact (2006) and, the most recent Tokyo Conference (2012). Most directly relevant to the UNFPA programmatic areas are the strategies to reach the MDG goals, especially #2, 3, 5 and 6, the National Reproductive Health Strategy 2011-2015, and the National Action Plan for Women (NAPWA) 2008-2018.

National strategies draw upon international instruments and respect principles set out in the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) and other human rights instruments to which Afghanistan is signatory, as well as the body of humanitarian principles and law as set out in the Geneva Conventions of 1949 and Additional Protocols, the Humanitarian Charter and international standards for humanitarian assistance.²⁰ Afghanistan submitted its first report on CEDAW in March 2012, nine years after joining the convention in 2003. The Elimination of All Forms of Violence Against Women (EVAW) law came into force on August 1, 2009 and the Attorney General's Office has taken the lead in prosecuting criminal offences against women by establishing a specialized prosecution unit on Violence Against Women (VAW) in 2010.²¹

The International Conference on Population and Development (ICPD) is supported by UNFPA based on consensus reached in 1994 among 179 governments for human rights based development and through recent reviews such as ICPD Beyond 2014.²² As per the Sphere Minimum Standards (2011) people needing humanitarian assistance have access to priority reproductive health services through the Minimum Initial Service Package (MISP).

Afghanistan National Development Strategy (ANDS), 2006

The ANDS lays out the strategic priorities and the policies, programs and projects for achieving the Government's development objectives. These are organized under three pillars: (i) Security; (ii) Governance, Rule of Law and Human Rights; and (iii) Economic and Social Development. The pillars on Governance, Rule of Law and Human Rights; and, (iii) Economic and Social Development supports and guides UNFPA's major programmatic areas. A number of Provisions and Strategic objectives support the implementation of UNFPA's Country Programs including:

- Strategic Objective: Health and Nutrition – “The ANDS strategic objective is to improve the health and nutrition of the people of Afghanistan through quality health care and promotion of health lifestyles. Reproductive Health focus is a core element of ANDS and has been essential in the overall health of Afghans (MoPH).²³
- Strategic Objective for Education: “The ANDS strategic vision for this sector is that regardless of gender, ethnicity, socio-economic status or religious affiliation, all Afghans will have equal access to quality education to enable them to develop their knowledge and skills and thereby maximize their potential.”
- Strategic objective on Social Protection: “The ANDS strategic objective for social protection is to assure that the benefits of growth reach the poor and vulnerable,”
- Cross-cutting Strategic objective on Gender: The ANDS goal for Gender equality is an Afghanistan where women and men enjoy security, equal rights and equal opportunities in all spheres of life.
- Cross – cutting Strategic objective on Capacity Building: “The ANDS capacity development objective is to ensure that the skills needed to effectively implement programs and projects included in the ANDS exist or can be developed within the required time frame for implementation.” Direct UNFPA support to strengthen the Central Statistics Office capacity to conduct National Census and strengthen capabilities to use data for decision making, best exemplifies this objective.

While there is currently no national strategy that guides the development of statistical systems, the ANDS fully appreciates the value of evidence based policy and strategy development. It recognizes that scarcity of consistent time series of geographically referenced socio-economic and demographic information (SDI)

²⁰ Humanitarian principles are set out in human rights, humanitarian law and principles governing the delivery of humanitarian assistance such as the Sphere Minimum Standards in Humanitarian Assistance, 2011.

²¹ IDLO: Know your rights and duties - The Law on Elimination of All Forms of Violence Against Women

²² UNFPA website

²³ Afghanistan's Reproductive Health Policy and Strategy, 2012–2020

constraints the capacity of the Government and other stakeholders to plan and implement evidence-based development efforts.²⁴

In 2013, a new ANDS is currently under development to meet the challenges of the GoIRA's emerging 'Transformation Decade 2015 - 2025'. The results of the ANDS have been recently evaluated. The current UNDAF is aligned with ANDS 2008 - 2013 but an extension for one year has been requested to align the next UNDAF.

Afghanistan Millennium Development Goals (MDGs) Strategy²⁵ – Due to lack of progress and available information lost during years of conflict, Afghanistan is aiming for 2020 instead of 2015, against baselines from 2002-2005 and has added an “enhance security” goal. While Afghanistan still ranks close to the bottom on global measures of health and nutrition, significant successes have been achieved in the past years in most of all the health outcome indicators reported on MDGs.²⁶ The Afghanistan MDG 2010 report has demonstrated the clear linkages between women’s education, maternal health, child health and mortality, and general family health. However, in assessing progress toward goals, data in some target areas are difficult to collect and in some (e.g. “reduce gender disparity in access to justice”), no clear data has been collected.

The National Reproductive Health Strategy, 2011 – 2015. Following the policy laid down in the ‘National Reproductive Health Strategy 2011-2015’, the provision of reproductive health services, family planning and STI/HIV prevention is almost exclusively provided within the context of the Basic Package of Health Services (BPHS) and delivered by national and international NGO’s. In recent years RH services have been made more accessible to women, e.g. through the training of a large number of female nurses and midwives and the introduction of Mobile Health Units.

The National Action Plan for Women (NAPWA)²⁷ focuses on three main outcomes: (i) Government entities embracing gender equality in their employment promotion, policy making and budgetary allocations; (ii) measurable improvements in women’s status as evidenced by reduced illiteracy, higher net enrollment ratio in educational and training programs, equal wages for equal work; lower maternal mortality, increased leadership and participation in all spheres of life, greater economic opportunities and access to control over productive assets and income, adequate access to equal justice, reduced vulnerability to violence in public and domestic spheres; and, (iii) greater social acceptance of gender equality as evidenced by increased participation by women in public affairs and policy discussions.

Afghanistan National Youth Policy. The draft policy was vetted to senior officials during the National Youth Policy Conference in June 2013. The policy was drafted by a technical committee from 13 line ministries and reviewed by 500 young men and women in workshops across the country. The policy’s main objectives is to design and implement strategies and programmes to promote the talent, skills and potential of young people, aged 18-30, defined as a priority group in the ANDS. It identifies gaps in existing youth related research, policies and programmes and provides a way to fill them, including through education and training, employment, health, volunteer activities, social inclusion youth and the world, and creativity and culture. The policy will be implemented by the Deputy Ministry of Youth Affairs under the Ministry of Information and Culture.

1.2.2 The Role of External Assistance

Since the vast majority of Afghanistan’s development budget is aid-financed, it must be responsive to the country’s needs and priorities, yet aid to Afghanistan has been criticized by the GoIRA as too prescriptive and driven by donor preferences. In response, several mechanisms have been put into place to make aid more effective, including means to fast-track the MDGs and poverty reduction.²⁸ Both the GoIRA and the international community recognize that prolonged aid dependency will undermine the chances of achieving sustained economic growth and poverty reduction.

²⁴ UNFPA’s Population Situation Analysis, 20 January 2013.

²⁵ Compiled from UNDP MDG website and Afghanistan Millennium Goals Report 2010

²⁶ Afghanistan Millennium Goals Report 2010

²⁷ National Action Plan for Women of Afghanistan (NAPWA) 2008-2018

²⁸ Afghanistan MDG 2010 Report, page 11.

Within the ANDS implementation plan, the Government has defined processes to increase the monitoring of aid-funded activities and to improve the efficiency of implementation design and operating procedures. The AID Coordination Unit in the Ministry of Finance (MoF) has the responsibility for issues related to the delivery and monitoring of external assistance. The Government would like to see increased core budget support (direct budget support), giving the greater ownership and enabling a more effective allocation of resources based on needs and priorities. Channeling aid through established trust funds is also effective, with the Government able to access funds on an as needed basis such as the Afghanistan Reconstruction Trust Fund (ARTF) managed by the World Bank.²⁹ Pooling of donor funds also significantly reduces the duplication of effort and leads to better coordination, management and effectiveness.

Efforts to increase capacity to implement the Core Development Budget more efficiently will result in higher donor contributions aiding in coordination. Equally important is the Government's accountability (and transparency) to Afghanistan citizens (and to external funding donors) how aid funds have been spent. The MoF's Public Expenditure Financial Accountability (PEFA) framework is crucial to this process. The ANDS provides the framework for priority aid delivery. The delivery of aid will be greatly improved where Government, civil society and the international community align expenditures with the ANDS priorities.

1.2.3 Funding, Implementing Agencies and Coordination Groups

The transfer of security responsibilities from ISAF to the Afghan authorities during the year 2014 will have consequences for overall international development assistance. In the health sector, for example, the total Ministry of Public Health (MoPH) health budget has increased from US\$ 55.3 million³⁰ in 2012 from \$38.3 million in 2009-2010.³¹ However, government revenue contribution to the health budget is less than 2%, with the rest sourced from donor funds. Of \$1 billion spent on health in 2008, \$787 million were out of pocket expenses by private households, putting a serious strain on the household budget for many Afghan families. Unfortunately, Sexual and Reproductive Health was not included as one of the function categories in the National Health Account (NHA) thus no figures can be provided about the government and out of pocket expenses to SRH.

Reproductive Health: In a period of 5 years (2005 – 2010) international donors increased their operational funds for reproductive health more than tenfold, from a level of US\$ 12.5 million in 2005 to US\$ 135.5 million in 2010. In 2009, family planning programs were supported for US\$ 45 million. In 2010 this amount was less, but as the figures for 2010 are still preliminary. Compared to the other components, external funds for HIV/AIDS have been much more limited; in 2010, US\$ 5.9 million were disbursed for HIV/AIDS programs and in 2010, US\$ 6.3 million was spent for the research component.

The MoPH runs two important programmes of great relevance to UNFPA's Country Programme: the Basic Package of Health Services (BPHS) and the Essential Package for Hospital Services (EPHS). The BPHS and EPHS are supported by three main donors: the EC, the World Bank and USAID. In 2009, US\$ 152.8 million was donated to population and RH activities: 47 percent of these funds were channelled through multilateral organizations and NGOs.

Within the health sector, two important changes are about to take place, **a**) the introduction of a SWAP (Sector Wide Approach) and **b**) the pooling of international financial assistance to health activities. These changes will determine the cooperation between the government, the international donors and the implementing partners. Within the SWAP, international financial resources will directly, through government channels, subsidize a sector-wide umbrella of services. The MoPH is one of four ministries where a SWAP will be installed. In the case of the MoPH, the distribution of funds will be guided by an agreed health sector policy initiated and directed by the government. Health programme activities will turn away from a vertical, project-based approach and will adopt a holistic methodology integrating service delivery. In essence, a SWAP calls for a partnership based on equality between government and donor agencies, with a clear government leadership and ownership. Preparations for a SWAP at the MoPH started in May 2011 with the installation of a Steering Committee and a Task Force. The Task Force is composed of representatives from the MoPH, the donor community and WHO, as UN-representative. The future mode of

²⁹ Afghanistan Reconstruction Trust Fund/World Bank

³⁰ The exchange rate of 31 July 2012 was used to make the conversion, 1US\$ = 0.0207598 AFN

³¹ Afghanistan Statistical Yearbook 2011-12, CSO Afghanistan, p. 109.

collaboration between the government and foreign donors will be laid down in the 'Health Sector Development Partnership'. The implementation of the SWAP is harmonized by a 'SWAP Technical Coordinator' within the Health Economics and Planning Directorate of the MoPH. Technical assistance is provided through an international technical cooperation program funded by the European Union. The SWAP will be implemented using a step-wise approach.

The pooling of international assistance is closely linked to the SWAP program. The general idea of this approach is that major donors will pool their development funds for health activities together and channel these funds through the MoPH. As no recent national health accounts (NHAs) have been produced, it is not known what percentage of development assistance for health currently flows through the government. The target is however that by the end of 2012, 70 percent of all international resource flows for health would be channelled through the government. The World Bank and the European Union have already agreed to pool their resources in the near future, but USAID will continue its current modality for financing health activities. For the moment, it is still unclear what stance other donors (i.e. JICA, GF, UNFPA, WHO, UNICEF and CIDA) will take. The MoPH does not consider that pooling all international funds through the government is crucial for the implementation of the SWAP, as long as donors who do not pool funds remain in line with the overall health strategy of the government.

The success of the SWAP and the pooling of funds are dependent on the confidence of the international donors in the implementation of the system. The MoPH will have to prove itself to be a dependable partner. The MoPH is well aware of this and is in the process to set up control mechanisms to assure transparency and accountability. Much will depend on the organization and the institutional capacity of the ministry. The MoPH realizes its present shortcoming in this field and aims to improve its capacity during the next five years. To increase transparency of the system, the ministry is planning to install an Aid Coordination Unit and to set up a database in which all activities, together with their budget amounts and expenses are brought together. As monitoring and evaluation are key to success in the SWAP, a reviewing committee will also be installed. Annual NHAs, with possible subaccounts, are considered to be crucial to guarantee accountability towards the donor community. To maximize program output, in addition to NHAs, in-depth analyses have to be done on aid effectiveness. The current capacity is insufficient to execute these studies and outside technical assistance will be needed. Another challenge will be to install a standardized procurement system. Also, with this aspect of the SWAP and the pooling of resources technical assistance and partnerships will be required.³²

Youth Empowerment: Unfortunately there is no analysis available on funds used to promote youth empowerment or gender equality. Under the National Joint Programming for Youth (NJYP, with 8 supporting agencies) managed by UNDP, numerous youth networks arose but many fell apart when the NJYP was discontinued in 2010 due to lack of political will, a low level of youth-specific content in the ANDS and lack of dedicated human resources and reporting from UN agencies. USAID has been operating a Skills Training for Afghan Youth (STAY) in two provinces. UNAMA through UN-Habitat supports a Learning for Empowerment Programme (LCEP-2) which promotes literacy, numeracy and vocational skills for older youth. UNESCO works on curriculum development with the Ministry of Education. The Deputy Ministry of Youth Affairs at the Ministry of Information and Culture is responsible for coordinating youth affairs. UNFPA has supported a Youth Advisory Panel (YAP).

Humanitarian Assistance: Funds for humanitarian assistance are a small percentage of external funding, approximately \$500 million compared to \$3.5 billion for development assistance. Humanitarian work is coordinated through a system of eight coordination clusters. RH in emergencies and humanitarian situations is coordinated under the Health Cluster chaired by WHO. The UN Country Team (UNCT) is separate from the UN Humanitarian Team (UNHT); the UNCT agencies are mainly development but include a small humanitarian component.

Population and Development: Between 2008 and 2009 funds to population activities have more than doubled and stood at US \$171.5 million in 2010.³³ Through activities conducted by CSO, supported by UNFPA and other donors, capacities to conduct large socio demographic surveys have gradually increased not only at the central level, but also in some provinces. An important contribution in the population area from the World Bank is related to the National Risk and Vulnerability Assessment (NRVA), a series survey which has completed a

³² Population Situation Analysis of Afghanistan, UNFPA, 2012, pages 17-18.

³³ ATLAS COGNOS Reports - Figures for 2010 are still preliminary.

fourth round. The NRVA aims to obtain and analyse data related to poverty, food security, livelihood and a wide range of other development indicators.

Gender Equality: A wide variety of actors cover this sector ranging from government, donors, INGOs, religious leaders, civil society and local level women's groups. The US Government has invested heavily in promoting gender equality and has developed its own strategy and coordination group within the US implementation partners.³⁴ UNFPA has been supporting the Gender Department of the MoPH to develop the concept for a model of coordinated response to GBV for Afghanistan. UNFPA initiated the establishment of the Afghanistan Gender Based Violence Sub-Cluster (GBV SC) as a national coordinating mechanism for prevention of and response to GBV, which is chaired by UNFPA and co-chaired by the Afghanistan Independent Human Rights Commission (AIHRC).

The MoWA, the MoI and the Attorney General's Office coordinate to provide a detailed report on the application of the EVAW law in each province, including the number of VAW cases brought to the police, disposition of each case (whether prosecuted or not) and the outcome of the prosecuted cases, which should serve as a baseline for future analysis of EVAW law implementation as per the Tokyo Mutual Accountability Framework.³⁵

UNFPA is also supporting the MoPH's plans for organizational and operational gender mainstreaming as identified in the Gender Strategy and Implementation Plan. The IASC gender marker system was applied for the first time in the CAP of Afghanistan where it was found that only 11% of the budget had gender as a principal aim.^{36 37} Almost 60 percent of the funding requirements were for projects where gender was addressed in only a limited manner.

³⁴ US Embassy Kabul Gender Strategy, for Interagency Gender Working Group (IGWG)

³⁵ Weekly Donor Meeting at Ministry of Finance, 28 July 2013, presentation

³⁶ IASC, Implementation of the Gender Marker for 2012 in CAPs and Pooled Funds, Analysis of Results and Lessons Learned, February 2012

³⁷ UN, Consolidated Appeal, Mid-Year Review, Afghanistan, 2012.

Chapter 2 UN/UNFPA Response and Programmatic Strategies

2.1 UN Response

2.2.1 The UN Development Assistance Framework (UNDAF) 2010-2014³⁸

The UN, particularly through its Assistance Mission in Afghanistan (UNAMA), is uniquely positioned to find consensus among Afghanistan's partners and to play a key role in coordination of international support for implementing the ANDS. In support of the National Development Strategy, the UN focuses on three fundamental priorities, including:

- (i) **Focus on the sub-national level to improve service delivery.** A focus on building institutional capacity at the Provincial, District and Community level(s), All UN Agencies are involved in building the capacity of their counterpart line Ministry with an overall objective to improve quality service delivery in a sustainable manner.
- (ii) **Comprehensive packages of UN support in selected provinces.** The UN Country Team (UNCT) system is applying a more focused, strategic and integrated approach in their program designs in order to catalyze and to increase efficiency in delivering aid and to the extent possible, avoid duplication of effort.
- (iii) **Offer new mechanisms to better coordinate assistance. The UN Common Fund:** To ensure the UN maintains its commitments to its development partners at the provincial and local level, it proposes a coherent fund-raising strategy as a bridge to funding any gaps for comprehensive provincial packages and joint programs – a UN Common Fund is to be created.

Table 1: Afghanistan UNCT Support and Alignment with ANDS (Ranked from one to four + with four being the most highly aligned with the ANDS)

ANDS Pillars	ANDS Sector No.	MDG No.	UNCT Programming	UNFPA Programming
Governance, Peace, Stability, Human Rights	1,2	9,3	++++	+ (PD) ++ (Gender)
Sustainable Livelihoods	3,6,8	1,3,4,8	+++	++ Gender
Basic Social Services (Health, Education, water, Sanitation)	4,5,7	2,3,5,6,7	++++	+++ (RH) +++ (Gender) ++ (PD) ++ (PD)

The UNCT in Afghanistan is among the largest in the world. The HCT, established in 2008, continues as the main policy and decision-making body under the Humanitarian Coordinator. Members include UN humanitarian agencies and NGOs with observers from the Red Cross Movement and donors. Links are also maintained with the Afghan Humanitarian Forum for NGOs and the Humanitarian Donor Group. Subsidiary groups of the HCT include the Inter-Cluster Coordination Team, the Emergency Preparedness Sub Work Group (established in Sept 2012), national coordination clusters, Humanitarian Regional Teams and regional clusters. The current UNDAF is aligned with ANDS 2008 - 2013 but an extension for one year has been requested to align the next UNDAF with the GoIRA's emerging 'Transformation Decade 2015 – 2025'. Progress on the new UNDAF is being made with the Common Country Assessment (CCA) that UNFPA has contributed to.

³⁸ UN Development Assistance Framework 2010-2013

2.2 UNFPA's Response Through the Country Programme

2.2.1 UNFPA's CP2 Strategy and Achievements³⁹

UNFPA's mandate promotes the organization to work in the areas of Reproductive Health and Rights (RHR), Population and Development Strategies (PDS) and Gender Equality and Women's Empowerment (GEWE). It is also mandated to work in humanitarian assistance and with youth networks and to fulfill a coordination role. UNFPA's second country programme (CP2) in Afghanistan was implemented from 2006-2009 with a budget of USD 39 million.⁴⁰ The CP2 aimed at providing strategic, policy and technical support to relevant governmental institutions, under the ANDS framework in UNFPA's core areas. Projects were implemented at the community level in mainly three provinces (Faryab, Bamiyan and Badakhshan) while more limited activities took place in Daikundi and Logar, through national and international NGOs. Other activities took place at the central level in Kabul, providing technical assistance and capacity building to GIRoA ministries.

In 2006, UNFPA's three core mandates were amongst the top socioeconomic challenges that Afghanistan needed to address. UNFPA had a mixed success in CP2; the majority of planned projects were largely implemented, but the sheer number of these activities meant that UNFPA was not able to effectively monitor the quality of implementation, contributing to the inability to achieve planned programme objectives at the outcome level and sometimes also at the output level. Programme achievements included the following:

- Although disappointingly, given the extensive preparations put into place, the 2008 population census could not be carried out due to security and other concerns, UNFPA's sustainable approach to supporting CSO demonstrated how long-term, committed capacity building activities can build institutional capacity and pave the way for a sustainable future collaboration.
- UNFPA had significant achievements in its RH work in capacity building at central level (supporting the development the 2006-2009 RH Strategy and the National Human Resources Development Plan for RH); sub-national level (supporting community midwifery education and increasing the family planning knowledge and skills of health providers); and at the service level (through funding MHUs and EMOC and supporting fistula service sites).
- Mobile Health Units (MHUs) have been highly effective in providing health care to remote and scattered populations. However, due to the demand for curative services, little time was spent on preventive measures, i.e. education and awareness-raising.
- UNFPA's global strategy of promoting male involvement in response to GBV and RH was adopted through its religious leaders programme, as they are key gatekeepers within the community on providing information and advice on health and family issues.

Strategic Shortfalls in the CP2

The CP2 ambitiously targeted multiple outcomes of the UNDAF and the ANDS. Consequently, the CO team was engaged in numerous partnerships and coordination mechanisms that required a range of strategic approaches, implementation modalities, human and financial resources, all of which were neither consistently available nor developed during the four-year period. This proved to be quite taxing on the organization. Other lessons included the following:

- UNFPA often opted for short term consultancies versus a more established technical presence with government counterparts, at the expense of both credibility and relationship building, leading to a less efficient use of the budget.
- The strategy developed under CP2 required a range of technical and management skills which were only partly available, thus the CO could build only limited institutional memory, and could not ground its partnership with government counterparts with solid long-term relationships.
- In humanitarian assistance, UNFPA's focus during CP2 has been on RH, with the distribution of RH kits in emergencies. UNFPA neglected its niche PDS mandate whereby it could rapidly provide data to help agencies make informed decisions about emergency interventions.
- Interventions for youth through the Youth Information Centers were not necessarily the most efficient means to promote ASRH awareness and the approach needed reassessment.

³⁹ UNFPA CP2 Evaluation Report, August 2010

⁴⁰ The Executive Board initially approved \$52 million for 2006-2008; \$11 million from regular resources and \$41 million from other sources. The CP2 was extended by one year to harmonize programme cycles. The actual budget available for 2006-2009 was \$39 million of which \$33.9 million was spent.

- UNFPA's support in the field of gender equality was somewhat inconsistent during CP2 and UNFPA needs to simplify the number of activities under the gender programmatic area as well as form a closer working relationship with the counterpart, MoWA.

The CP2 evaluation recommended that UNFPA prioritise the objectives and refocus the activities in a simplified framework, taking a long-term perspective to capacity building for a reduced number of institutions at the national, provincial and field levels. Operationally, UNFPA must improve the learning from implementation by enhancing the quality of monitoring and evaluation. UNFPA must continue to improve and rationalise its systems, improve filing, document important decision-making processes and spend more time closer to project implementation i.e. with the counterpart at the ministry and in the field, monitoring projects.

2.2.2 UNFPA's Strategic Response in the CP3⁴¹

Given the national context, the other actors in UNFPA's mandate areas and the programmatic facilitating and constraining factors, UNFPA has strategically planned its CP3 approach taking into consideration the CP2 evaluation recommendations to focus on fewer outputs, and reduce the number of government partners and targeted areas to maximize results with UNFPA's limited resources. The CP3 has been implemented since January 2010 and will end in December 2014 transitioning into another programme, the CP4. Major donors to UNFPA Afghanistan include Denmark, Sweden, Iceland, Italy, Canada and Japan.

CP3's Strategic Connections to International Guiding Principles and National Strategies

Against the backdrop of a rapidly changing political, security and development environment described above, the CP3 was designed based on the priorities as set out in the MDGs, the global summit of 2005, the ANDS and the UNDAF. Lessons learned in CPs 1 and 2 were also used. The CPAP 3 is contributing to the three major priority areas of UNDAF, which in turn are tied to the ANDS and Afghanistan's MDG strategy, among others, as follows.

1. Governance, peace and stability (ANDS sectors 1 and 2; Afghanistan MDG 9 and 3)
2. Sustainable livelihoods: agriculture, food security and income opportunities (ANDS sectors 3, 6 and 8; Afghanistan MDGs 1, 3, 4, 8)
3. Basic social services: health, education, water and sanitation (ANDS sectors 4, 5 and 7; Afghanistan MDGs 2, 3, 5, 6, 7).

Geographic concentration. In CP3, UNFPA concentrated its efforts both geographically and functionally and avoided a more thinly stretched programme as recommended in the CP2 evaluation – the CP2 stretched to 19 provinces. UNFPA continued to provide assistance to Badakhshan, Bamiyan, and Faryab provinces, which remained largely accessible throughout the CP3. The provinces were selected based on consultations with the government and the UN Country Team and criteria included: high incidence of poverty and large underserved populations, including ethnic minorities and IDPs, community openness to change, previous involvement and established relationships and support from local government. Other criteria included minimum levels of stability and security and opportunities to collaborate with other UN agencies. Assistance was extended to Daikundi, which in 2009 was identified by the UNCT as the province in which the entire UN system in Afghanistan aims at "Delivering as One". The Gender Equality activities were extended to Nangahar. Activities have recently been extended to Herat Province with Italian government support.

Targeting of the most vulnerable. UNFPA's programmatic areas defacto include the most vulnerable, e.g. women and girls, minorities, and youth, among others, and programmes have been targeted to reach the underserved and unserved populations. Specific strategies for the most vulnerable communities, such as the Kuchis and IDPs have been included to some degree.

Cross programme strategies. With regards to youth and gender, UNFPA pursues strategies that cut across the three programme components, involving: (1) policy dialogue and evidence based advocacy for establishing

⁴¹ Compiled from: Evaluation Team analysis; Final Version Country Programme Action Plan (CPAP) 2010 - 2013, 14 March 2010; Evaluation of UNFPA's 2nd Country Programme in Afghanistan 2006-2009, Final Evaluation Report, June - August 2010, Atai Consulting; UNFPA Afghanistan Annual Report 2011-2012; UNFPA Country Office Population Situation Analysis (PSA) for Afghanistan of September 2012; UNDAF Mid-Term Review, 2012. ,

an enabling environment, (2) gender-sensitive, life-skills-based ASRH education and youth friendly SRH services, (3) research on youth dynamics and (4) participation of women and young people in decision-making processes.

In CP2, UNFPA was recognized largely for its work on family planning and support for the census but receded in comparison to larger agencies on other aspects of RH and GE. More emphasis was placed in CP3 on long term technical assistance rather than short term and service delivery. At the same time, UNFPA has found its particular niche among services related to policy, law, and fistula management, where it can set standards that can eventually be taken to scale.

Partnership and coordination strategy. Country leadership and ownership are highlighted in line with the Paris Declaration (2005), and the Accra Agenda of Action (2008), UNFPA applied the principles of country ownership, alignment, harmonisation, managing for results and mutual accountability, all particularly important for CP4 as Afghanistan transitions. The Ministry of Foreign Affairs (MoFA) is one of the main partners of UNFPA in its role as principal coordinator of the Country Programme. The CP2 evaluation has highlighted sustainability as an area where more effort is needed by UNFPA to ensure durable transfer of KAP and consequently, several CP3 outcomes target sustainable capacity development.

The CP2 evaluation noted the need for UNFPA to strengthen interagency partnerships with multilateral, bilateral donors and other international development agencies in order to improve information and knowledge and to

Table 2: CP3 Programmatic Activity Areas

Theme	Activities
Reproductive Health, Reproductive Health Commodity Security (RHCS) and Family Planning Obstetric Fistula Family Health Houses Mobile Health Units	<ul style="list-style-type: none"> • RH: Campaign to end fistula; Community Midwifery Education (CME); Emergency Obstetric Care (EmOC); technical and management capacity building to MoPH and Provincial Health Directorates (PHD); technical assistance on RH strategy development • RHCS: Technical assistance to MoPH for strengthening RHCS management including training and provision of equipment and software; development of RHCS strategy • Family Planning: Establishment of FP training facilities; communications campaigns; training of health workers on FP methods • Provision of basic health care to communities outside of catchments areas of stationary facilities under the BPHS by means of Family Health Houses and Mobile Health Units across UNFPA focus provinces
Population and Development	<ul style="list-style-type: none"> • Supporting the Afghanistan Population and Housing Census to improve availability and utilisation of population data disaggregated by sex, age, and geographical area; conduct and disseminate Bamian Socio-economic demographic survey (SDES); conduct SDES in Ghor and Daikundi and prepare/conduct SDES in Kabul, Panjsher, Parwan, and Kapisa
Humanitarian Assistance	<ul style="list-style-type: none"> • Development of disaster management plans in relation to RH and provision of RH kits and dignity kits for emergency situations
Youth Empowerment and Sexual and Reproductive Health	<ul style="list-style-type: none"> • Support for development and roll out of the Afghanistan National Youth Policy; Establishment of a call center health/help line in Kabul youth friendly hospital space to respond to anonymous calls on reproductive health; operation of one Youth Information center with peer counselling training, and dissemination of ASRH information, advocacy for gender equality and life skills training
Gender-based violence (GBV)	<ul style="list-style-type: none"> • Strengthening the technical and management capacity building of MoWA and DoWA • Establishment of centre for information management and media in MoWA • VAW issues incorporated into the training curriculum for health service providers • Inclusion of gender and ethics modules in police academy training, support to women in prisons

promote more effective coordination, collaboration and resource mobilization. In particular more work was needed for stronger UN agency “Delivering as One”, and in the area of youth empowerment to avoid overlap

and duplication as occurred between UNICEF and UNFPA. The coordination mechanisms through the UNCT need to be widely used by UNFPA to gain exposure for its strengths. Among the coordination mechanisms are: the UN security meetings, basic Health Service Cluster, Protection Cluster and Humanitarian Cluster. UNFPA is lead agency for HIV/AIDs on the UNCT and assumed leadership of the GBV sub-cluster under the Protection Cluster in 2013, which should help to gain needed visibility.

Partnerships with Local Government and Civil Society – Partnerships mean that civil society stakeholders will also be directly involved in the design, planning, monitoring and evaluation stages of the individual projects; partners include Community Development Councils (CDC); various NGOs; Afghanistan Civil Society Foundation (ACSF), Afghan Red Crescent Society (ARCS) and Gender Studies Institute (GSI); academia, such as Kabul University and the American University; media; network of CBO, such as the Afghan Women’s Network (AWN); and professional associations.

The Paris declaration and aid effectiveness principles and the use of national systems and processes implies that the capacity of government ministries and departments need to be built. Thus, in terms of capacity building and sustainability, a strategic choice and balance needs to be made on the distribution of capacity building resources for national and international NGOs and Government ministries/departments as implementing partners.

2.2.3 Programme Management

Human Resources: In 2007, the planned organigram showed 25 office staff out of a total of 40 staff while the most recent organigram contains 80 positions. The CO reports to the Asia and Pacific Regional Office (APRO) in Bangkok and APRO staff may participate in the CP coordination structure.

Results Based Management. The implementation of the 3rd Country Programme is monitored and evaluated as guided by the UNFPA procedures and guidelines and by the principles of Result-Based Management (RBM), Human Rights Based Approach (HRBA) to programming and will be aligned with the ANDS and UNDAF Results Matrix. A distinction is made between situation monitoring (i.e. monitoring progress towards achieving national goals to which the UNFPA Country Programme contributes) and performance monitoring (i.e. the monitoring and evaluation of the activities of the UNFPA Country Programme). The CPAP is implemented on the basis of the *Annual Work Plans*. All the activities of the AWP will be accompanied by at least one process indicator for enabling UNFPA and IP to monitor progress. In addition, each (sub-) AWP will specifically include monitoring and evaluation activities.

In the absence of an M&E database for UNFPA, RBM reporting is a major challenge. IPs are reporting on the numbers, however, more emphasis is required to strengthen reporting on the tangible results and also reporting on progress through process indicators and milestones and how these contributes to output indicators. There is also an absence of linkages between MoPH HMIS and IPs HMIS database and its consolidation at CO level through a HMIS database and through DEVINFO.

2.2.4 The Financial Structure of the CP3

Among the programmatic foci, CP3 funds are divided as follows:

Resource Allocations (total of \$38.8 m)

Reproductive Health = 54.1%

Population and Development = 28.4%

Gender Equality = 15.5%

Programme Coordination = 2.1%

This varies from the CP2 as follows: Actual budget = \$39-40 million of which 48% was spent on RH, 45% on PDS and 7% on gender. The reduced funding for PD allowed the RH component to be more fully supported as recommended in the CP2 evaluation, and GE as a basis for promoting access to RH services augmented.

Chapter 3 Analysis of Programmatic Areas – Reproductive Health

3.1 Reproductive Health Objectives and Activities

At the 1994 International Conference on Population and Development (ICPD) in Cairo, 179 countries adopted a 20-year Programme of Action, which focused on individuals' needs and rights, rather than on achieving demographic targets. The foundation of the ICPD is completely relevant in Afghanistan today and notes that Reproductive Health (RH) is elusive because of such factors as: inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives. Adolescents are particularly vulnerable because of their lack of information and access to relevant services in most countries.

The ICPD goals are incorporated into UNFPA's CP3 and include: a) To ensure that comprehensive and factual information and a full range of reproductive health-care services, including family planning, are accessible, affordable, acceptable and convenient to all users; b) To enable and support responsible voluntary decisions about child-bearing and methods of family planning of their choice, and to have the information, education and means to do so; and (c) To meet changing reproductive health needs over the life cycle and to do so in ways sensitive to the diversity of circumstances of local communities.

The CPAP Results Framework includes the following:

RH Outcome 1: By 2014, utilization of high-quality RH information and maternal health and family planning services is increased in selected provinces.

Output 1.1: increased institutional capacity of the MoPH to perform its stewardship role in relation to ensuring the availability of and demand for quality reproductive health services.

Output 1.2: Strengthened capacity of health facilities and service providers with a focus on selected provinces, to provide antenatal and post-natal care, basic and comprehensive emergency obstetric care and fistula treatment.

The RH programmatic area was the most resource intensive of the CP3 and covered a large number of activities. Activities largely centered on Badakshan, Bamiyan, Faryab and Daikundi provinces with limited activities in other provinces, such as Kabul province. The outcomes and activities under RH are analyzed below with regard to relevance, effectiveness, efficiency and sustainability. These include:

- Institutional strengthening of the Ministry of Public Health (MoPH)
- Institutional strengthening for Reproductive Health Commodity Security (RHCS)
- Support to Afghanistan Midwife Association (AMA) and the Midwifery Profession
- Obstetric Fistula (OF)
- Pilot Family Health Houses Plus Mobile Support Teams (FHH + MST) Model of Service Delivery to Remote Areas

3.2 Relevance

Institutional Strengthening of the MoPH. UNFPA's support for the MoPH to update its RH Strategy, especially regarding the Safe Motherhood Initiative (SMI) and Family Planning (FP) is important to strengthen RH services needed by the Afghan people as well as to help achieve MDG 5 concerning reduction of Maternal Mortality. The RH strategy caters to the ICPD agenda which promotes increased choice of modern FP methods and empowerment of women to implement their choice through male involvement, as well as advocacy with

Religious Leaders to accept the practice of FP in the context of Islam. Through UNFPA's participation in H4+⁴² to accelerate reaching MDGs 4 and 5, all H4+ activities have been accepted as part of the National Priority Program (NPP). The UNFPA Annual Work Plan (AWP) for 2013 is totally aligned with the NPP.

Institutional Strengthening for RCHS. In Afghanistan there is need to ensure continuous availability of modern contraceptives due to low contraceptive prevalence rates and high fertility rates. In general, countries seeking to develop an RH Commodity Security (RHCS) Strategy are those who have been supported by a donor to purchase such commodities. The BPHS is being funded and implemented by three donors, USAID, the EU and the World Bank, who are also supplying FP methods; at least 3 methods should be available in each health facility. Typically, donors find ways to ensure institutionalization and financing procurement of RH commodities for when they withdraw their support. The three major donors have not set out their exit strategies yet, nevertheless, a strong RHCS Strategy is especially important as donors may start to withdraw their funding and support, given the objectives for autonomy in 2014.

Support to Midwifery. In Afghanistan, RH services depend heavily on midwives as service providers. The UNFPA together with the International Confederation of Midwives (ICM) are conducting a global program "Investing in Midwives". Afghanistan has joined this endeavor in 2009 and the Afghanistan Midwifery Association (AMA) and MoPH Nursing and Midwifery Department in collaboration with UNFPA and other key stakeholders, have developed a National Policy and Strategy for Nursing and Midwifery Services 2011-2015. The goal of the policy is to ensure provision of quality nursing and midwifery services to the people of Afghanistan, e.g. protection of the public from unsafe practices, which will in turn contribute towards enhancement of their health status.

Raising the capacity of midwives is highly relevant to raising the quality of RH services. However, UNFPA's work with the AMA falls under CPAP output 1.2 only indirectly, as it states "Strengthened capacity of health facilities and service providers, with a focus on selected provinces, to provide antenatal and post-natal care, basic and comprehensive emergency obstetric care and fistula treatment". The CPAP Output 1.1 which is about institutional strengthening is only geared toward strengthening the MoPH. In the next CP, outputs need to be phrased that reflect 1) institutional strengthening of AMA, 2) establishing and functioning of the Nursing and Midwifery Council of Afghanistan (NMCA) and execution of its action plan, and 3) development of a National Midwifery Education and Faculty Development Plan.

Obstetric Fistula (OF). Poor women with OF risk being divorced or separated from their husbands and left to a life of dependency on a family member with their children. UNFPA's payment of transportation and per diem to women who go for OF repair makes treatment of non-complicated cases more affordable and accessible to women. A major constraint to relevance is the limited coverage for fistula repair in only one or two provinces. There is insufficient coverage of cases in the country and training for the surgeons does not address the complicated cases.

Pilot Family Health Houses (FHH). Afghanistan has many remote and mountainous areas where the population is very scattered and not reached by the BPHS. It is estimated that 43% of the population of Afghanistan lacks health services within 10 kilometers or a three hour walk. These areas are known as "white areas" which have been identified on the MoPH's provincial strategic plans. UNFPA with its implementing partners (IPs) support a Community Midwifery Education (CME) program where women are selected from their communities and return to serve the same community in the FHH, ensuring that they will be acceptable to the communities. The services provided include RH services in addition to Integrated Management of Childhood Illnesses (IMCI), and newborn care. The FHH + MSTs will contribute to achievement of MDGs 4 and 5.

Participants attending the CP3 Participatory Dialog workshops attested to the relevance: *"There were populations that had no access to health services; and, the FHH provided access to health services for these people, which will have an effect on maternal mortality and infant and child mortality."*; *"The services provided by*

⁴² The H4+ is a global initiative aimed at harmonizing actions to improve maternal and child health involving 6 UN agencies (UNFPA, UNICEF, WHO, UN Women, UNAIDS and the World Bank). In Afghanistan they work with the MoPH to accelerate reaching the MDGs through an H4+ action plan and they are joined by other agencies including USAID, CIDA and the International Confederation of Midwives.

the FHH and MSTs were also found to address the community needs by a provider who is from the same culture and thus acceptable to them.”

3.3 Effectiveness, Efficiency and Sustainability

3.3.1 Institutional Strengthening of the MoPH

Effectiveness

UNFPA has supported the MoPH to update its RH Strategy, especially regarding the Safe Motherhood Initiative (SMI) and Family Planning (FP). It has also supported development of new chapters in the strategy concerning: 1) women's health issues such as obstetric fistula and cervical cancer; 2) increasing women's FP choices such as implants and postpartum intrauterine devices (IUD) as well as male involvement; and, 3) miscellaneous strategies such as RH in emergencies and post-training follow up and supportive supervision.

Additional technical assistance was provided by UNFPA to translate the RH Strategy into an action plan with its own estimated budget. UNFPA advocated with donors to adopt this action plan, consequently, a working group composed of all relevant stakeholders now exists for every chapter of the RH strategy. The working group mobilizes resources and distributes tasks of the national RH action plan for implementation. UNFPA also funds three consultants (for SMI, FP, and RHCS) at the MoPH Reproductive Health Directorate (RHD) to assist in the implementation of the RH Strategy.

Following are descriptions of the institutional capacity building activities that UNFPA implements in collaboration with the MoPH RHD. In general, the RHD staff assessed the activities as relevant and effective. Guidelines for RH services agreed by the RHD have helped to create ownership. The UNFPA either trains master trainers or provides TOTs to MoPH trainers and the MoPH then rolls out the training nationwide. Thus UNFPA supported training is very likely to have contributed to improved quality of service delivery.

Family Planning Training

FP Competency-Based Training. UNFPA supported a ten-day training course for midwives and female medical doctors from all over Afghanistan. The RHD staff reported that the training is very effective as it promotes skills and detailed information on FP to newly graduated midwives and female doctors. This training helped to fill gaps in formal education as curricula only briefly present FP and do not include some essential information and skills such as counseling.

Post-abortion care and postpartum IUD. Training on post-abortion care and postpartum IUD was first introduced by USAID in 2009-2010 and currently UNFPA has taken the lead to train more midwives on postpartum IUD, starting with regional hospitals. UNFPA supported training for six surgeons in Iran and they are now performing permanent surgical FP methods such as tubal ligation and vasectomy in regional hospitals.

Introducing FP Implants to Afghanistan. The MoPH conducted a rapid assessment on the ability of the health facilities to provide the implant. Four providers from MoPH will be trained as master trainers in Bangkok on insertion and removal of implants and will train other government providers in Kabul, Herat, Mazar-e-Sharif and Jalabad on a pilot basis that should be evaluated first in terms of acceptability and appropriateness, before rolling it out on a wider scale in provinces. UNFPA started this work in September 2013 in conjunction with Pathfinder International and the MoPH.

Male Involvement in FP. A major issue with regard to contraceptive use is that women need their husbands' permission to use them. Midwives see this as jeopardizing their efforts to promote FP. The husbands may seek the advice of male health providers which is not always favorable to the use of FP methods. In response to this common problem, UNFPA targeted male service providers with training aiming to help them to dispense accurate FP information.

The Family Health Alliance conducted a 3-day TOT for MoPH trainers and then the training was rolled out to the four UNFPA focus provinces plus other provinces that had lower levels of FP utilization in 2012. The training curriculum was insufficient, so it was revised to include needed topics such as methods of counseling. A refresher TOT was conducted and retraining of male service providers in eight provinces has been planned. The male involvement training was very useful to male health service providers in their daily contacts with male

patients and in responding to their queries. It is now feasible to extend male involvement training to all other provinces.

Promotion of FP. UNFPA effectively produced information, education and communication (IEC) materials for the promotion of FP, such as short videos, brochures, posters and notebooks. UNFPA plans to produce mass media campaigns on FP with funds recently obtained from the Global Program for Reproductive Health Commodity Security. UNFPA has already worked with media staff, especially journalist on the benefits of FP for the health of women and children as well as the envisioned contribution to social development of the country and the living conditions of the people. UNFPA made a one-day briefing about FP for civil society organizations, Shuras and various associations. Given the increasing trends in urbanization and the youth bulge, UNFPA should pursue filling the information needs for Adolescent and Sexual Reproductive Health (ASRH) and contraceptive needs in the urban areas. (See Annex 4 on recommended Behavior Change Communications activities.)

Advocacy with Religious Leaders (RL) for Family Planning (FP)

As there are misconception in Afghanistan about the permissibility of practicing FP in the context of Islam, even among Mullahs and other Religious Leaders. UNFPA worked with Religious Leaders extensively during the CP2 and worked in 2012 with the Ullama High Council, Ministry of Hajj and Religious Affairs (MoHRA) and Afghanistan Academy of Science to advocate for FP in the context of Islam. The CP2 evaluation noted the following finding.

With the situation of women in Afghanistan, the high prevalence of violence against women, the denial of education, access to health-care and economic independence, along with the influential status of religious leaders throughout the country, UNFPA's work with religious leaders and the Ministry of Hajj and Religious Affairs is highly relevant.

UNFPA supported a regional conference in Afghanistan for Religious Leaders (these leaders include male mullahs and religious scholars) concerning their involvement in FP. The event was successful and one of the recommendations was to conduct a similar but national conference for Afghanistan. The UNFPA conducted a national conference under the title of "Islam and FP" with 2 senior RL attending from 22 provinces. Religious scholars as presenters were effective in convincing the senior religious leaders. At the end of the two-day conference the RL signed a declaration that they fully support FP. The declaration was made into a poster that was distributed to midwives to use in convincing women to practice FP. This poster would be useful for male health service providers who have attended male involvement training to highlight the confirmation by the Religious Leaders.

An Egyptian book called "Family Planning in the Legacy of Islam" was translated to Dari and Pashtu and was distributed at the end of this conference and other events that include Mullahs. There are plans to conduct similar conferences in other provinces such as Herat and Mazar-e-Sharif. It was planned for RL to make a visit to Egypt to share experiences from the Al-Azhar University in involving RL and preachers in advocacy activities for FP, however, due to security issues in Egypt this activity was postponed.

UNFPA is also working with Mullahs' wives to sensitize them to become role models for the FP program. From feedback of MoPH, RL and other stakeholders, UNFPA advocacy was thought to be successful and well-targeted to the Religious Leaders. Books of exemplary Friday prayer speeches for preachers (*Khutaba*) could be a useful tool. The MoHP's vision to conduct a TOT for RL to train all Mullahs in the 5 regions of Afghanistan may come to fruition.

Training for MoPH on Cervical Cancer Screening

UNFPA is supporting the MoPH in developing a programme for screening, diagnosis and management of cervical cancer; screening for cervical cancer is carried out in the community through inspection after applying acetic acid (vinegar). The cervical cancer programme will be evaluated and rolled out to regional hospitals in the provinces.

Training of Midwives in Conjunction with the AMA

In 2010, UNFPA funded in-service training for AMA midwife members from all provinces on Basic Emergency Obstetric and Newborn Care (BEmONC), FP, Obstetric Fistula (OF) and Minimum Initial Service Package (MISP) for RH. This refresher training is continuously needed to improve quality of services provided by

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midwives. The training was effective in capacity building for midwives; it is likely that the training of midwives for a number of years by the MoPH, supported by UNFPA among others, has contributed to the drop in maternal mortality that was measured in 2010.⁴³

Another capacity building activity that UNFPA supports is cost sharing with the AMA in advocacy events such as the International Day of Midwives, Mother's Night and the Annual Congress of Midwifery, where international guests as well as midwives from all provinces attend. There are many presentations which allow midwives to update their knowledge. The last Annual Congress was in April 2013. The Annual Congress also allows midwives to network and share challenges with MoPH decision-makers. Advances in midwifery in Afghanistan and other countries are also shared.

3.3.2 Institutional Strengthening for Reproductive Health Commodity Security (RHCS)

Effectiveness

The UNFPA provides contraceptives to the MoPH facilities, and central and provincial level Pharmacists and Stock Officers have been trained on a Logistical Management Information System (LMIS), and the Channel Software, which enables stock management and forecasting of needs as well as reporting back to the RHD on RH commodities. Twenty-two Provincial RH Officers were trained on this software, data management and on RHCS and supplied with computers and printers.

With support of UNFPA, MoPH has formed a Coordinated Procurement and Distribution System (CPDS) Committee in 2011 with participation of different partners and donors. This should enable all donors to report on availability of commodities and pharmaceuticals in warehouses in different provinces, i.e. identify the needs and be able to forecast. UNFPA is providing technical assistance through two technical advisors at the FP Department at MoPH one of them is tasked with supporting RHCS and coordinating the CPDS committee. There are many challenges faced with relation to coordination of commodity security as well as management of the pipeline, cold chain and warehouses. Particularly in the provinces, the cold chain and the warehouses are reportedly not of high quality or in sufficient numbers, although the capacity development needs and options were not explored in this evaluation.

Efficiency and Sustainability

UNFPA supports procurement of government contraceptives for regional and teaching hospitals. UNFPA has introduced the Channel software and trained staff on its use in management of FP supplies and to forecast needs. It has also supplied the necessary computers and printers. However, the training was premature and underutilized since few PHD are applying the Channel software as RHCS is not in the RH Strategy and thus not part of the government system.

Thus far in the CP3, the MoPH and UNFPA were not able to find support for technical assistance to develop the planned RHCS strategy and action plan to strengthen coordination among FP implementing partners, however, funds are now secured through the UNFPA APRO. The RHCS strategy has to be relevant to the special context of Afghanistan where FP methods are supplied by donors and their IP/NGOs.

A workshop on RHCS for MoPH RH stakeholders and donor representatives was held to support development of an implementation plan for pooled procurement and commodity security. In view of the changes proposed through the SWAP and pooling of funds, the components of the projects need to be spelt out clearly and clear results mapped out and action plan of activities and indicators at output and activity levels. The RHCS strategy and its framework of results, indicators and activities is crucial because it will clearly set out of which components of the projects can donors intervene and provide assistance.

⁴³ Urban and Community Midwives training since 2005 has received support from national and international non-governmental organizations including the European Commission, the United States Agency for International Development and the World Bank, and multilateral partners such as UNICEF, the United Nations Population Fund and the World Health Organization.

3.3.4 Support to the Afghanistan Midwives Association (AMA) and the Midwifery Profession

Effectiveness

UNFPA and the MoPH work with the AMA to raise the status of midwives in the Afghan society and in government. The status of midwives is very low because their education tends to be below secondary level, compared to international entry level standards of completion of 12th grade and entering at least on a college diploma level. In Afghanistan the standards had to be lowered to grade 9, especially for Community Midwives (CMW).

UNFPA's activities are effectively leading to the establishment and institutionalization of the NMCA to elevate the standards of nursing and midwifery practices and protect the profession from non-midwives practicing midwifery, through licensing of midwives. The council may also require that midwives continuously upgrade their education and training in order to be re-licensed. The licensing may also be graded according to level of education and skills. UNFPA has also been supporting refresher training for midwives. The issues with the training include the following:

- Midwife trainers need more up to date knowledge and skills themselves as the trainer and trainee are at the same level. Trainers thus need to be trained at least to the bachelor degree level. For creating the bachelor degree, Afghan midwives at the master's degree level are needed to act as faculty.
- It is difficult to get international faculty to teach Afghan midwife students as midwives usually do not speak English. Solutions proposed are to enable prominent skilled midwives to attend English taught midwifery courses or for national trainers to interpret for international trainers.

The mentorship program is an AMA initiative funded by the Swedish Committee for Afghanistan (SCA), whereby the AMA gives refresher training and support to newly graduated midwives working in Comprehensive Health Centers, Basic Health Centers and Sub-Centers. AMA has shared its SCA mentorship program concept note with UNFPA and UNFPA has expressed interest to implement this for the FHH CMWs. The mentorship program is especially needed for CMW in the UNFPA FHH model as was recommended and requested by UNFPA IPs that implement the FHH model, as the CMW is trained for less the two and a half years and is alone providing services in remote areas. Up-skilling of CMWs must be accompanied with appropriate incentives to retain their services at FHH level, otherwise, the tendency is there for them to move to BPHS or EPHS and the collapse of the FHH model. On the one hand graduation of CMWs to BPHS and EPHS level is a good sign and indicates acquisition of skills and capacity and thus must be encourage but with proper long term succession planning of CMWs transition to being midwives at BPHS and EPHS. It provides that opening and entry point of midwives from the very basic level as CMW at FHH levels.

The following activities were undertaken in support of the AMA and the NMCA.

Development of the ACT for an NCMA. Hence, UNFPA and AMA in collaboration with MoPH Nursing and Midwifery Department and key stakeholders have developed the Act for an NMCA, which articulates the rule, composition and function of the council. This is a legal document that is enacted pursuant to the Constitution of Afghanistan in which the state should adopt necessary measures to regulate medical services. The Act is currently in the Ministry of Law and Jurisdiction to produce the law governing the establishment of the NMCA.

Capacity development for Decision Makers. An international Midwifery Specialist conducted two workshops for decision-makers including MoPH to work on a 5-year strategy and action plan to create the NMCA. The first workshop was conducted in 2012 and the second in 2013.

Development of the Strategic Plan for the NMCA 2013-2017. The Plan encompasses strategies for addressing gaps in the three pillars for strengthening the midwifery profession and association (education, regulation and professional association) and build on ICM global standards and the Act. An M&E Framework for this Strategic Plan has been produced. The Strategic Plan is currently in the process of being signed by the Midwifery Steering Committee, chaired by the Director of the Directorate of Curative Medicine under which lies the Nursing and Midwifery Department. In addition, a position at the MoPH Midwifery Department has been advertised to oversee and coordinate the implementation of the Strategic Plan.

The Act and the 5-year strategy and action plan provide an effective foundation for the education, employment and deployment of midwives as well as addressing the current gaps. Afghanistan is thus reported to be ahead of other countries in the region in this respect. The next steps include the following:

- UNFPA-supported Midwifery Specialist together with AMA will use the framework to develop an education strategy for midwives and a faculty development plan.
- UNFPA as part of a South to South Collaboration and partnership with UNFPA/Iran is going to help develop faculty staff and review the AMA curriculum to ensure it fulfills ICM's essential competencies for midwives.
- The AMA mentorship program for midwives requires evaluation as a basis for funding by UNFPA
- Obtain funding for AMA projects such as the mentorship projects for the CMW of the FHH.
- Continuation of refresher training every year to upgrade knowledge of midwives
- Establishment of a Bachelor Degree Program for new midwives and a bridging programme to help midwives already working to obtain bachelor's degrees – these plans have already been submitted to the Ministry of Higher Education for review.
- Obtain funding to establish infrastructure and staffing for the NMCA and its operations.

Efficiency

UNFPA previously funded AMA in-service training, however; now UNFPA only gives AMA a consultancy fee. It would be more efficient to provide AMA with funds for complete projects and in-service training through the Organization of Afghan Midwives (OAM), which can now receive funds as per Afghanistan government regulations. It may be more cost-effective and visible for UNFPA to support AMA in conducting complete projects aimed at enhancing the skills and status of midwives, rather than supporting short events described above. When the AMA needs to fund an event it has to apply with a detailed budget of the event for receiving UNFPA money. However, due to UNFPA's slow disbursement processes, the money is received after a long period of time. Thus, UNFPA is not one of the major donors for AMA and UNFPA work for the midwifery profession is not as visible as it could be.

There has been no organizational assessment of the AMA to identify weak areas that need strengthening so that they are able to 1) write proposals requesting funds, 2) handle large amounts of funds, and 3) implement programs that will enhance their work and promote the work of UNFPA in midwifery. The AMA does not currently have the capacity to respond to calls for proposals resulting in not being able to access UNFPA funding for implementing projects. The capacity of AMA can be assessed through the use of ICM tools to identify gaps, such as how to have a mission and a vision as well as how to do strategic planning.

Sustainability

Other donors are also helping the AMA to establish the NMCA through their participation in workshops to develop the council strategy. Recently, UNFPA has approached the Swedish International Development Assistance (SIDA) to fund the physical establishment of the organization. Financing mechanisms have not been put in place to determine the sources of continuous financing of the NMCA. These are critical factors that will determine the effectiveness and sustainability.

3.3.5 Prevention and Repair of Obstetric Fistula (OF)

Effectiveness

UNFPA has twice supported an international trainer to provide services in Kabul for basic surgery for fistula repair. The head of the RHD finds that repair of non-complicated cases of OF is very successful. In addition, the Head of the Malalai Maternity Hospital (MMH) reports the success rate of basic OF repair as about 95%. However, 10%-15% of OF patients received by the MMH require advanced surgery to repair their complicated OF. These women are turned away with negative implications for the reputation of the MMH as a national center for repair of OF. There is also negative psychological effects on poor women, who may also have borrowed money to come from the provinces for treatment. Thus there is a need for advanced training for physicians on OF repair.

There are two issues regarding the provision of advanced fistula repair surgery: security restrictions for international travel of surgeons to Kabul, and weak English skills of the Afghan surgeons that may hamper their ability to get the most from training in other countries. Possible solutions are providing support for OB/Gyn

surgeons to travel to countries well known for treatment of OF such as Ethiopia. Support for English language courses for selected competent OB/Gyn surgeons will enable them to go for training abroad, thus permanently building capacity on fistula treatment for Afghanistan.

UNFPA provides support for the Afghanistan Society of Ob/Gyn (AfSOG) to train the 28 branches of the society on prevention of fistula. Physicians are encouraged to avoid performing surgery immediately, since natural repair is possible for small fistulae. The head of the Afghanistan Ob/Gyn Society feels that the poor medical practices have been reduced after the training. For example she does not receive as many uterine ruptures as before as well as she believes that there are better prospects for survival of patients in Badakhshan where maternal mortality used to be high. A needs assessment concerning surgical needs was conducted about 4 months ago by Dr. Suhaila of the MoPH RHD.

Insufficient coverage also emanates from not knowing the magnitude of the problem in Afghanistan; although limited surveys have been conducted, data analysis is not conclusive for national prevalence. The SDES may be able to include a module to capture data on Obstetric Fistula. As prevention is more effective than treatment, a needs assessment/ KAP survey for the community understanding of causes of maternal mortality and obstetric fistula can help to design more effective IEC and media campaigns for preventing obstetric fistula and promoting natural healing. Prevention and interventions can be facilitated greatly by a better understanding of the pathways of obstetric fistula, understanding the major determinants and underlying causes of OF. The awareness-raising could be conducted through the public media, schools and reaching out to adolescents as well as in mosques at the Friday prayer.

Efficiency

There are insufficient regular coordinated planning, monitoring and supervision visits conducted by UNFPA and RHD to the MMH, in order to solve implementation problems and to discuss what needs to be done. This is especially important as resources are few and need to be managed efficiently. Currently UNFPA staff visits the MMH only every 2-3 months. In fact, the MoPH RHD wants UNFPA to coordinate these monitoring and supervision visits. Thus coordinated planning, monitoring and supervision to MMH needs strengthening.

The RHD had selected the five Ob/Gyn specialists that have been trained in basic OF repair. Three of these physicians are from hospitals other than MMH. They had agreed to conduct OF repair in MMH however, after training their hospital chief of department did not allow them to perform surgeries in MMH. The lesson is that training programmes have to select candidates based on their availability to contribute to addressing the needs, thus MOUs or agreements with the health institutions may be required to ensure that expensive training is not wasted.

Sustainability

The MoPH supplies the MMH with drugs and medical supplies. At present, due to decentralization, the MMH is able to autonomously buy their supplies. The UNFPA also supports the MMH by providing supplies as well. At the time of the evaluation, the head of the MMH was overstocked and UNFPA staff were reviewing the stock to avoid overlap in providing supplies. The UNFPA may want to concentrate more on providing the sustainable inputs to OF repair, which are the basic and advanced training of providers and the provision of needed equipment to MMH as well as provincial hospitals. In addition to sustainability, this would also increase accessibility without the continued UNFPA financial support to OF patients to access services. However, training of providers on repair of OF, when their hospitals do not provide such service wastes resources and takes away from proper targeting of training at providers who will sustainably provide the repair services to women.

3.3.6 Pilot Family Health Houses (FHH) Model of Service Delivery to Remote Areas

Effectiveness

The MoPH with UNFPA support has developed 82 functional Family Health Houses (FHH) and 9 Mobile Support Teams (MST) in white areas. Both activities are currently in the pilot stages. UNFPA also supports 4 Mobile Health Teams (MHT). The FHH + MSTs are operating in Faryab, Daikundi and Bamiyan ; in Herat they will be established over the next two years. In Badakhshan, there are no FHHs and only MHTs are operational in remote areas. The piloting of the FHH and mobile health services holds potential for expansion to assist the many people in white areas who must travel long distances to reach health services. UNFPA support only

covers four of 34 provinces with the FHH+MST and one with the MHTs. UNICEF provides MHTs to serve uncovered areas in several other provinces.

Choosing the communities to implement a FHH

The IPs conduct community mapping to collect data on villages and communities and their populations. This data is compared to the Provincial Health Directorate (PHD) strategic plan. The first step in establishing a FHH is to get the approval of the PHD:

1. **Needs Assessments and Mapping** are done at the provincial level for white areas not covered by the BPHS as identified by the PHD strategic plan. They are then coordinated with the provincial Governor, provincial council, the provincial level of MoPH, the provincial department of women affairs, and provincial education department. The community requests services from the MoPH. If the mapping is in line with the PHD strategic plans then permission to establish the FHH is granted.
2. **Selection of Students:** Once it is approved by all stakeholders, then the CME students are selected based on Participatory, Assessment, and Planning for Sustainable Livelihood (PAPSL) methodology
3. **CME Education:** The CME students receive a 26 month--2 years normal CME education and a two month additional education or extra curriculum developed by UNFPA. Two months are added so that the midwives learn how to manage the FHH and to report on the Health Management Information Systems (HMIS). The CMW students also study Integrated Management of Childhood Illnesses (IMCI), new born care and nutrition as well as first aid, as there is no nurse with her to offer these services i.e. the extra period is to enable her to manage all services in the community. The CME education takes place either in the center of the province or in Kabul.
4. **Service by Mobile and Construction of FHH:** Until the family health house is established the people are served by mobile health teams while the construction is completed. The construction takes place during the second year of CME education.
5. **Service Delivery at FHH:** When the midwives have been placed in the FHH, the number of MHTs are reduced and they only backstop the FHH as follows:
 - Assist CMW of FHH in HMIS, and other management issues;
 - Treat patients that are beyond the technical authority of a community midwifery worker's level
 - Supply the FHHs
 - Vaccinate the children under five and women of childbearing age
 - Transport/Refer some of serious cases to higher level of health facilities.

Community Midwifery Education (CME) program

UNFPA and IPs faced numerous challenges at the beginning of CME implementation. After lessons learned were incorporated into planning, there are near zero CMW drop-outs, after initial retention rates of about 95% of CMW as reported by one IP.

Some of the challenges included the reluctance of families of females to let their daughters or wives travel for education. This is resolved by involving community *Shuras* to convince families that the services are needed by the community. Also IPs often show the family of the CMW the hostel in which she is going to stay and the place where she would be taught, stressing the fact that there are no males present. Another challenge is ensuring that the CMW provides services to her community. Unmarried CMW may become married and move out of the community. The local authorities sometimes wanted a CMW from a certain community to go for CME, while the FHH was needed in another community. There were other discrete cases where for one reason or another, the CMW did not return to her community.

The MoPH has devised criteria for selection of the CMW; UNFPA and the Provincial Health Directorate (PHD), and Provincial Councils are part of the selection team. In addition, community participation is an important part of the selection process, as the *Shuras* and elders of the community are the ones to ascertain and ensure that the selected CMW comes back to serve the community after being trained. The family of the CMW as well as the *Shuras* of the area also sign papers promising that she will return to serve the community.

A persistent challenge in the selection of CMW from remote areas is the high level of illiteracy. The MoPH has agreed to lower its requirement of completion of grade 9 to enter midwifery education, which is already lower

than the international standard of grade 12, to completion of only grade 6 but with competence in reading and writing. If the village does not have a female educated to that level, then this remote community will not have an FHH. In effect these vulnerable remote communities, which are deprived of female education, are thus also deprived of health services. If the gender and geographic gap in education is not addressed, this has further negative implications for accessibility of females to needed RH services and the vicious circle continues.

Family Health Houses (FHH)

To implement the FHH + MST model of health services, community participation is key not only in selection of CMW but they also share in funding and building the FHH, with some financial support from UNFPA and managed by the *Shuras*. The FHH consists of one examination room, one delivery room, a waiting area and a toilet. During the implementation, a lesson was learnt that such rooms were not sufficient so the design was revised with one additional room and a small stockroom. The evaluation team visited a FHH in Bamiyan province and observed the presence of appropriate technology used to provide quality Reproductive, Maternal, Newborn and Child Health (RMNCH) services.

The CMW works with the community and family decision makers to ensure that women receive preventive care services. The CMW is supported by two Community Health Workers (CHWs); one male and one female who work voluntarily. There is also a Family Health Action Group (FHAG) per 1000, which are women volunteers who are responsible for ten to fifteen families. The CHWs and FHAG are responsible for demand creation activities such as raising awareness of needed services and encouraging women to utilize the services. The male member of the Health *Shura* and the male CHW meet the husband and male family members to convince them about the importance of FP.

Mobile Support Teams (MST)

The MST is scheduled to visit the FHH every month or once per two month (according to Mobile Package of Health Services (MPHS) policy of MoPH). Each MST is considered a Service Delivery Point (SDP), which supports several remote villages having FHH. Each MST has four staff: a medical doctor or a nurse, a midwife, a vaccinator/female health educator and a driver/male health educator. The driver also helps in some administrative matters. The IPs train the MST staff and provide them with the needed supplies. The MST visits the FHH and gives technical and managerial support to the CMW. The MSTs vaccinate and provide Primary Health Care. As the communities are small they are aware when the MST arrives and go for the needed services.

Challenges faced by the FHH + MSTs include the following.

- Traveling in insecure areas as well as traveling through mountainous areas especially in the harsh weather in winter with snow. The FHH visited reported that the MSTs come every month but not in winter. Funds are available to use animals instead of vehicles. UNFPA is thinking of other strategies to address this issue in Bamiyan.
- MSTs previously shared their action plans with the FHH, which was a good practice. However, it increased their probability of facing danger, so they stopped informing the communities beforehand.
- IPs face difficulties in conducting capacity building for providers in the provinces due to lack of availability of qualified trainers and specialized hospitals with adequate caseload and mix. Refresher training is recommended for CMW, midwives, nurses and doctors. UNFPA can send specialized trainers to the provinces and perform competency-based training.
- IPs and the CMW report that the workload is heavy as the targets set for her may be unrealistic since the population size tends to be underestimated. In addition, due to good quality of services provided in the FHH and lack of other nearby services, neighboring communities also utilize the FHH services.

The following are testimonials of provincial stakeholders to the effectiveness of FHH + MST in increasing access to and utilization of health services in remote areas.

- ❖ *There were populations that had no access to health services. The FHH provided access to health services for these people, which will have an effect on maternal mortality and infant and child mortality*
- ❖ *Training and capacity building of CMW and physicians increased their capacity to better care for patients*

- ❖ *The selection of CMW from these very remote areas makes her instrumental to the health of her community better than a doctor who is a stranger to the community and may be culturally inappropriate to serve the community. This will have an effect on maternal mortality and infant and child mortality*
- ❖ *Before establishing the FHHs, there were MHTs that went to very remote areas and had very good impact on the health of remote communities.*
- ❖ *A community based structure composed of the CHWs, health Shura and the FHAG makes good health education activities thus increasing utilization and hence will have an effect on maternal mortality and infant and child mortality*

Outcomes and Impact

The availability of FHH in remote areas helps save lives. The visited FHH CMW gave an account of having saved a woman's life. Thus there is anecdotal evidence that presence of FHH with well-trained CMWs would likely contribute to lowering maternal mortality as well as infant and child mortality. The CMW recounted:

I had one emergency case last year. It was winter time and in the middle of the night someone knocked on the door and asked for help. A woman from the same village who had delivered in her house two days earlier was in serious condition. The placenta had not been expelled (retained placenta) and urination was obstructed. The woman was almost in a state of shock. I had one serum bottle, a pair of surgical gloves and a catheter and inserted the catheter and connected the serum. I then was able to pull the placenta out and the woman's life was saved.

The beneficiaries testified regarding important outcomes of the UNFPA FHH + MST health care model:

- Birth spacing and contraceptive use increased in the community
- There was a lot of resistance to give water (ORS solution) to a child with diarrhea, but now they have been convinced that it is good for its health.
- Through the work of CHW and Shura and FHAG now people know how to take care of their personal hygiene
- The MHTs come to vaccinate but it is because of the work of the CHW now people go for immunization
- Maternal and child death have decreased because of the establishment of the FHH and the work of CHW, which have increased access to and utilization of health services.

Efficiency

As the CMW is being trained, for 26 months, the areas are served by Mobile Health Teams (MHT). The MHTs are exactly the same as MSTs, except that the MST's function is to provide vaccinations and to technically support the CMWs serving in FHHs, while the MHT provides services on its own. The MHTs are thus not always available in a community to provide services. Furthermore, the MHTs / MSTs are reported to be far more expensive than FHH by UNFPA staff, IPs as well as the Deputy Minister of MoPH, as the mobile teams are relatively costly in human resources, fuel and vehicle rent.

Implementing the FHH + MST is more cost effective than implementing the MHT alone, which should only take place as designed, only during training of the CMW. For example, one of the implementing partners was operating 8 MHT in a province. When 35 FHH were built and functioning, these 8 MHTs were replaced by 3 MSTs only. However, in Badakhshan the IP is implementing the MHTs alone. It is reported that it was planned that WHO would implement the FHH in the province. Thus, UNFPA applied for funding only of the MHTs in order to complement WHO efforts in the province. However, the donor accepted funding the UNFPA project only. As a result the UNFPA is implementing the MHT that is known to be less cost-effective than the complete FHH +MST model.

UNFPA technical support to IPs has been reported to be sufficient. Funding is adequate and there is flexibility in reallocation of budgets. IPs are reported to be working in conjunction with the provinces and relationships with the PHD are good. IPs may come under pressure from stakeholders in the provinces and thus monitoring by UNFPA is critical to support the IPs and troubleshoot any managerial issues. Very little monitoring by UNFPA took place in the first two years of the implementation of the FHH+MST however, in 2012 and 2013, the monitoring visits were increased to become bi-monthly to give feedback to the provincial and central level IP. Monitoring needs to include and coordinate with the MoPH RHD and M&E department since the FHH is part of the national RH strategy.

Sustainability

When MHTs and the FHH static health facilities are compared, the FHH is more sustainable since the construction and operation of the FHH is far less expensive. For example, a decrease in UNFPA funding during the CP3 affected the number of MHTs that could be operated and resulted in a reduction in communities served. Furthermore, although MHTs are part of the BPHS, the Deputy Minister of MoPH reported that the MoPH cannot sustain them if donor funding stops. Thus it would appear that the static health facilities are more sustainable and this should be tested through a costing study.

For the pilot FHH to become regularized and sustainable, they must be integrated in the BPHS with MoPH funding. The following factors must be addressed for sustainability to be realized.

1. Sustaining community partnership and ownership of the concept and model
2. Continuous learning and up-skilling of CMWs into new and appropriate technology in maternal and RH.
3. Providing the necessary incentives for CMW retention
4. Developing a competency based training and assessment and reward CMWs based on performance
5. Succession planning and transiting into BPHS
6. Providing the necessary supporting infrastructure through joint programming with relevant agencies (i) water, telecommunications and electricity and roads – also work outside the normal health system
7. Low cost transportation for CMWs for community advocacy and awareness
8. Reliable telecommunications and transport systems for strengthened referral

The FHH is very cost-effective as it is served by only one midwife and the community builds the FHH and contributes 30% of the costs. In addition, even though there is substantial investment in training the CMW, their monthly salary is not high. The MoPH can also sustain it because the FHH is within the RH strategy of the RHD. However, the Deputy Minister indicated that the pilot project of the FHH + MST + CME has to be rigorously evaluated before he considers including it in the BPHS.

3.4 Management of the RH Programmatic Area

UNFPA receives high marks for its technical assistance to the MoPH and for its cooperation with other organizations. UNFPA has also provided effective technical support to its implementing partners (IPs) with adequate financial resources and demonstration of flexibility in reallocation of funds. The partnerships with the IPs have resulted in good working relationships with the provincial Public Health Departments. UNFPA participates in the RH taskforce, the RH working groups and committees and is a member of the cancer, OF and FP committees.

However, many partner agencies said that UNFPA needs to play a more active role in coordinating with other UN organizations and government counterparts working on the same development problems to promote addressing common issues with one voice. Staffing shortages or unfilled positions have affected the impact of UNFPA's interactions - sometimes UNFPA is not present for discussions and planning meetings. It is important that UNFPA staff be visible at meetings to represent the agency's point of view while seeking collaboration with other agencies that have greater funding resources. Some examples of areas where stronger coordination and collaboration is required are as follows.

- In its transversal role among youth, population and development and RH, UNFPA should take a stronger leadership in the early child marriage campaign, an initiative which will be re-strategized in the near future among UN Women, UNDP and other agencies. Collaboration should be discussed with UNDP which has funds to dedicate to the campaigns against early marriage
- UNFPA needs to make its voice more strongly heard through the UNDAF and the UNCT on women's rights, including for RH.
- UNFPA staff need to be regular attendees at the MoPH Technical Working Groups, to change the current perception that there is weak participation and follow-up by UNFPA.
- The government does not provide funds for the MoPH to carry out its stewardship role, thus good coordination is required with donors to secure needed funds and to support MoPH's role.

- Communication and coordination roles among UNFPA, the MoPH and the AMA should be clarified with the MoPH Deputy Minister to avoid misunderstandings regarding the Midwifery-led Maternity center which is a collaboration between UNFPA and the AMA but which was also seen by the MoPH as being part of its strategic plan.
- The MoPH and UNFPA need to specify and unify their plans for addressing cervical cancer to promote efficient use of resources.

Joint Monitoring

The UN advocates for joint monitoring to improve collaboration and to avoid gaps and duplications. In particular, more interaction between UNFPA and the MoPH is needed for monitoring joint activities, such as for the MMH and the FHH, as they are part of the RH strategy. For example, greater involvement of the MoPH and UNFPA is needed to support the MMH for planning and problem solving. Regular joint monthly monitoring visits are important to support the institutional development of the MoPH for oversight of the MMH Fistula center. Very little monitoring by UNFPA took place in the first two years of the implementation of the FHH +MST however, in 2012 and 2013, the monitoring visits were increased to become bi-monthly to give feedback to the provincial and central level IPs.

Chapter 4 Analysis of Programmatic Areas

-Adolescent Sexual and Reproductive Health and Youth and Development

- Humanitarian Assistance

4.1 Adolescent Sexual and Reproductive Health and Youth and Development

4.1.1 Objectives and Activities

UNFPA's global focus on adolescents and youth is based on the recognition that young people, particularly those living in poverty, have been virtually ignored in policies and programmes. UNFPA's *Framework for Action on Adolescents and Youth* articulates the organization's multi-sectoral strategy to promote the comprehensive development of young people worldwide. Its four pillars include:

- addressing population, youth, and poverty issues at the policy level
- expanding access to gender-sensitive, life skills-based sexual and reproductive health including HIV education in schools and community settings;
- promoting a core package of health and sexual and reproductive health/HIV services
- encouraging young people's leadership and participation within the context of sector-wide approaches, poverty reduction strategies and health sector reforms.

The CP2 evaluation pointed out that only one of the four pillars had been fully addressed in Afghanistan, neglecting other key elements of UNFPA's global approach. In particular more work is needed for stronger UN agency "Delivering as One" in the area of youth empowerment to avoid overlap and duplication.⁴⁴ UNFPA has a new global strategy, "*UNFPA Strategy on Adolescents and Youth*", released in early 2013. This strategy should be applied for the remainder of the CP3 and will be reflected in the Annual Work Plan for 2014 and for the CP4. The new strategy presents a five pronged approach:

1. Enable Evidence-Based Advocacy for Comprehensive Policy and Program Development, Investment and Implementation
2. Promote Comprehensive Sexuality Education
3. Build Capacity for Sexual and Reproductive Health Service Delivery (including HIV prevention, treatment and care)
4. Take Bold Initiatives to Reach Marginalized and Disadvantaged Adolescents and Youth, especially Girls
5. Promote Youth Leadership and Participation

The **CPAP 3 Outcomes, Outcome Indicators, Outputs and Output indicators** most applicable for youth-related activities are found in two programmatic areas:

RH Outcome 1: By 2013, utilization of high quality RH information and maternal health and family planning services is increased in selected underserved provinces

Output 1.2: Strengthened capacity of health facilities and service providers to provide ante and post natal care and basic EOC and fistula repair.

Output Indicator: % of people above 12 years of age who know three danger signs during pregnancy and know where to access health facilities, including MHU and CMW, for RH services.

RH Outcome 2: By 2013, young women and men adopt healthy life styles

⁴⁴ The evaluation team did not receive the management response to the CP2 evaluation.

Outcome indicators: a) Gender sensitive life skills based ASRH integrated into national curricula of primary and secondary schools, madrassa and teacher; b) % of women aged 16-24 who were married before ages 16 and 18.

RH Output 2.1: Increased availability of RH information and life skills education at the community level, focusing on girls and boys both in and out of school in the most underserved districts of the target province.

Output indicators: a) % of young people who can identify ways of preventing GBV, STI and who reject major misconceptions; b) % of teachers in catchment areas of MHU trained on providing life skills training to students; c) % of communities with a trained peer educator promoting RH knowledge; d) % of young people who can name at least three modern contraceptive methods.

PD Outcome 2: Development, planning and allocation of resources prioritizes the needs of young people

Output 2.1 Strengthened institutional capacity to create and monitor programmes for young people

Output indicators: a) Planning, monitoring and reporting tools available for integrating youth and gender in development planning; b) # of selected national government and district administrations with skilled staff to collect and analyze data and disseminate information on gender and youth.

Activities, Outputs and Outcomes/Results (See “expected versus actual” results matrix in the annexes.)

For the next CPAP, UNFPA needs to carefully apply results based thinking to streamline the programme outcomes, outputs and indicators that directly pertain to youth. For RH Outcome 2, planned activities were not fully carried out relevant to the indicators. For example, no work on child marriage was included in RH, rather it was covered under the gender programme but interventions included in the GBV component, made them less relevant. The focus on law enforcement may be less effective in preventing child marriage compared to working to change community attitudes. Under RH Output 2.1, the results framework largely focuses on youth and emphasizes the increased availability of RH information and life skills based education at community level. However, it is noted that the framework fails to spell out how these can be achieved; the indicators do not provide much detail about services available at the community level or in the health facilities. Thus there is a missing linkage on the provision of holistic youth friendly services which not only address RH services but all aspects of youth empowerment at community and health facility level.⁴⁵

Given the serious development challenges related to the youth bulge (see the background section on youth in Chapter 1) the indicators for the next CPAP need to be strengthened. In terms of the RH Output Indicator, under Output 1.2, the relevance of this indicator could be challenged based on current theories of change to increasing utilization of RH services by adolescents. It is unlikely that young adolescent girls’ knowledge of danger signs is a deciding factor – targeting parents and in-laws is more relevant, as they would determine health seeking behavior.

UNFPA’s activities directed at youth in CP3 basically include three major projects in addition to advocacy and capacity building. These are: support for development of the Afghanistan National Youth Policy (ANYP); Youth Information Centers and peer counseling networks; and establishment of the Youth Health Line. The Youth Advisory Panel (YAP), established in 2010 with the support of UNFPA, is a youth support system to strengthen the role of young people in the Afghan society.

The Country Office Annual Report (COAR), 2012, reported that:⁴⁶

- In 2012, UNFPA provided technical support to the Government of Afghanistan through the Deputy Ministry of Youth Affairs in developing the National Youth Policy with contribution from stakeholders and youth organizations.
- Through the establishment of Youth Advisory Panel (YAP), UNFPA contributed to the youth programme and project.
- As part of capacity building strategy UNFPA trained youth in and outside of the country on relevant programmatic issues particularly on ICPD related issues.

⁴⁵ Update on (internal) Review of CPAP indicators, January 2013

⁴⁶ The 2011 COAR was not available to the evaluation team.

- UNFPA met with the population and development sub-committee of the Afghan Parliament on population related issues, particularly on youth empowerment, high fertility and high population growth.
- The youth friendly service manual has been revised by a working group comprised of representative from MoPH, UNFPA, UNICEF, WHO and Deputy Youth Ministry and meetings were led by MoPH with close technical support by UNFPA and a three day TOT carried out.

4.1.2 Relevance

Participants at the CP3 evaluation workshop in Kabul (September 2013) highlighted the applicability of the UNFPA global mandate for supporting youth in the Afghan context. Currently the UNFPA CO supports a “palate” of youth related activities likely selected as achievable in the difficult operating environment with relation to government capacity, and security and access concerns. Nevertheless, UNFPA should focus more strongly on identifying areas of vulnerability and then targeting them, as per its mission statement. For example, some globally and nationally relevant activities and areas of focus are missing: *No activities related to marginalized adolescent girls were included in the AWP 2012 (COAR 2012).*

During the upcoming preparations for the next UNDAF, including the CCA, UNFPA can advocate for greater clarity of purpose regarding targeting of youth and this process will include using the draft Afghanistan National Youth Policy as a vehicle to lobby for strong youth outcomes at the first UNDAF stakeholder meeting at the end of October. It is expected that youth will be mainstreamed throughout the new UNDAF priority areas.

Age and sex matter. Relevance is challenged by differing definitions of categories of youth, and hence targeting for youth activities. Globally, the United Nations understands adolescents to include persons aged 10-19 years and youth as those between 15-24 years for statistical purposes. Together, adolescents and youth are referred to as young people, encompassing the ages of 10-24 years. Due to data limitations, these terms can refer to varying age groups that are separately defined as required.⁴⁷ Findings on adolescent sexual and reproductive health appear to be piecemeal perhaps due to the merging of adolescents with both youth and adults in studies, resulting in lack of a holistic approach to the specific problems faced by emerging adults in gender, RH and PD programmatic areas. In Afghanistan for ASRH, UNFPA uses the Afghanistan Mortality Survey and the Afghanistan MICS which have disaggregated data for young people aged 15-19 and 20-24 respectively. MICS would also cover ages 10-14 for some indicators.

Childhood (in line with the UN Convention on the Rights of the Child defined as anyone below the age of 18) is identified based on physical, mental and psychological changes that prepare a person for maturity. According to the legal system in Afghanistan, the childhood period is divided into three phases: undiscerning minor aged 0-7 years, discerning minor aged 7- 13 years and adolescents (juvenile) aged 13-18 years. According to the Afghan criminal law, minors are children between the ages of 7-13 years. In light of the Afghan labour law, a juvenile is a person who has completed the age of 14 and has not completed 18 years of age.⁴⁸ However, some youth related programmes may cover up to age 30. Clarity is thus needed by stakeholders as to age and sex in programme and project documents regarding assessments, targeting and results based planning.

Afghanistan National Youth Policy (ANYP)

Support for the ANYP development has been extremely relevant to the context in Afghanistan and UNFPA’s global mandate. The ANYP was designed in line with the vision of the ANDS (2008–2013) and the National Priority Programmes (NPPs) as well as the Millennium Development Goals (MDGs) and follows numerous articles of the Constitution. The policy’s main objectives are to promote the talent, skills and potential of young people, aged 18-30, defined as a priority group in the ANDS. However, the ANYP also provides guidelines for programming for adolescents (13-18 years) recognizing that for many sectors, including health and education, the return on investment is particularly high when made at earlier stages in life. It identifies gaps in existing youth related research, policies and programmes and provides a way to fill them, including through education and training, employment, health, volunteer activities, social inclusion of youth and the world, and creativity and culture.

⁴⁷ Adapted from UNFPA Global Website: Adolescent and Youth Demographics, a Brief Overview

⁴⁸ Draft Afghanistan National Youth Policy, page 7.

Youth Information Centers (YIC) and Peer Education and Youth Health Line

Since 2009, UNFPA's funding for technical support and staff salaries and operations costs, channeled through the DMOYA, has supported four Youth Information Centres, in Kabul, Herat, Nangahar and Mazar-e-Sharif with. The purpose of the YIC is to address ASRH issues among youth using a holistic focus and with particular attention to out of school youth. The mechanisms used included promotion of an ASRH curriculum jointly developed among eight ministries, and providing life skills, through for example, computer and English classes, and by drawing in community and religious leaders. The YIC relevance needs to be tested as it was not a successful concept thus far in the Afghan context; the CP2 evaluation recommended considering alternatives to reaching similar and broader audiences of youth. Given the stigmas that exist in Afghan society regard ASRH, the anonymous caller line is relevant to protect identities and dispense information on demand but results may be difficult to follow up.

Youth Advocacy and Research, Institutional Strengthening

UNFPA's global goal is to strengthen capacity of youth-serving/youth-led organizations/associations and networks to be able to engage in the design, implementation, and monitoring of programmes addressing SRH and HIV needs. According to the 2012 COAR, the resources, institutions and policy and legal frameworks to address the SRH needs of young people through community led organizations and networks remain poor (score of 3 out of 10).⁴⁹

The CO provided technical and financial support to the country's first participatory *Youth Assessment Study* aiming to better understand the youth situation, their needs, priorities, challenges (prepared by Samuel Hall Consulting, report being finalized). The CO is currently finalizing a comprehensive *State of Youth Report Afghanistan*.

The YAP was a group of eight men and women from different provinces networking with youth organizations to monitor difficulties and aspirations, and to develop ideas on how to respond to the needs of youth and better support them to participate in future UNFPA activities. With UNFPA support, YAP members undertook several study tours to different provinces of Afghanistan in order to meet youth and identify their needs and concerns. They also had the chance to meet a Youth Advisory Panel in Pakistan to exchange ideas and experience a different approach to active citizenship.

The first panel of 12 members completed their term at the end of 2012, however, the results were not satisfactory to either UNFPA or the panel members. Panel members felt that their advice was not taken into account and that the YAP approach lacked continuity and structure. Based on effective implementation documented by the APRO in Nepal, Cambodia and Mongolia and supporting good practices for the UN Delivering as One, the CO is now working toward establishing a "UN Youth Advisory Panel" during 2014/2015. The inclusion of youth organizations in the development of the youth policy was an effective model for further work on youth participation.

4.1.3 Effectiveness

The participants at the CP3 evaluation workshop in Kabul (September 2013) identified the following positive outcomes of the CP3.

- Access to ASRH services (information, counseling and referral) through the help line in Kabul and provinces
- Increased capacity and empowerment of youth on RH, HIV, STI and Gender through Peer education
- Increased institutional capacities of Government counterparts and IPs through workshops and trainings
- Increased the confidence of youth on utilizing health services
- Increased awareness of the needs of adolescent and youth (policy, advocacy and research)

⁴⁹ UNFPA Afghanistan Country Office Annual Review, 2012, page 14/33

Weaknesses were seen to be: poor coherence and continuity, limited coverage and limited focus on behavior change outcomes. The 2012 COAR assessed the national capacity to be weak in terms of resources, institutions and policy and legal frameworks for engaging youth in policy dialog and planning while the development and inclusion of youth focus in national plans and programmes was substantially better.

Some planned interventions in the CPAP 3 Results Framework (see box above) were not carried out, e.g. for RH Output 2.1 (Indicator: % of teachers in catchment areas of MHU trained on providing life skills training to students), teacher training was not carried out. On the other hand, some activities have no outcomes, outputs and indicators such as those on advocacy, leadership and research. Some indicators appear to have no baseline: (e.g. % of people above 12 years of age who know three danger signs during pregnancy and know where to access health facilities, including MHU and CMW, for reproductive health services), or plans to follow-up on the indicator. These should be re-thought to be more realistic for the next CPAP. The planned RBM training for the CO in November 2013 should assist to streamline the results framework.

Afghanistan National Youth Policy (ANYP)

UNFPA played an effective and major supporting role in the development and roll-out of the ANYP through a process considered to be participatory, jointly undertaken among relevant agencies and government-led. The policy was drafted by a technical committee from 13 line ministries and reviewed by 500 young men and women in workshops across the country. Financial and technical support for the National Youth Policy development process came from the Government in partnership with the ILO, UNDP, UNFPA, UNICEF, ISAF, and USAID's implementing partner Counterpart, among others. The process used was a vast improvement on the previous effort in 2009 when a policy modeled from India was translated to Dari; coordination of the approval process led by UNDP was weak and it was not adopted.

The draft policy is well developed and was vetted to senior officials during the National Youth Policy Conference in June 2013, attended by 400 participants across the provinces. The policy will be implemented by the Deputy Ministry of Youth Affairs in the Ministry of Information and Culture. The challenges in implementing the policy include:

- The policy has not been approved by the Cabinet and while the conference served to lobby for the policy, the policy requires close follow-up to ensure its passage through the legal system
- The Deputy Ministry of Youth Affairs suffers from human resource weaknesses in terms of oversight capacity and this has affected the effective and efficient use of resources for achieving the CP3 objectives (see Youth Information Centers discussion below) as well as implementing the ANYP.

Youth Health/Help Line

Guidelines were developed in 2011 for establishing a health line for young people, in collaboration with the MOPH, UNICEF, WHO and a national NGO, Afghan Family Guidance Association (AFGA). This health line was piloted initially in Kabul in 2012 and is widely considered to be very successful in eventually answering an average of 1,500 anonymous calls per month (as many as 150/day), including a number of inappropriate calls that need to be screened out and not counted as part of the total) country-wide from centers in Kabul. Many callers seek basic sexual and reproductive information that is not available to them otherwise. Data is recorded based on a well-organized menu of topics, including GBV and psychosocial issues, and a checklist noting characteristics of the caller. The database serves as a proxy assessment on the sexual and reproductive information needs of adolescents and youths. A comprehensive advocacy plan was developed in 2012 through print and electronic media; billboards; posters; and radio and television messages which resulted in a 200% increase in calls. An evaluation of the health line needs was planned for 2013 but was not carried out, rather a review of the pilot project will be conducted in preparation for expansion to other provinces.

The location of the health line centers in a hospital with counselors (two men and two women in separate rooms) who are physicians familiar with reproductive services and youth friendly spaces, is likely to increase the probability that callers will seek medical care if required; referrals are given to the closest health facility as per locations on a map of Kabul province. The counselors have received training supported by UNFPA in Pakistan where 6 provinces are served by a similar help line. Counselors said training in Lahore was very beneficial especially in trouble shooting the issues on how to respond to sensitive questions by telephone and information on how to expand the activity to other areas of the country.

Complementary to the health line, production of publications by AFGA from their core funding, such as those helping adolescents understand their changing bodies are distributed in the youth friendly space and through schools, although this is currently done on a limited basis.

Challenges with the youth health line include:

- Calls are received from other provinces, and stakeholders emphasize the need to extend the help lines to the provinces, given the obvious demand.
- The call density is such that callers have to be put on hold for a number of minutes as some consultations require a long time, consequently callers may hang up unserved.
- The phones in use are older models and newer technology is needed to improve user friendliness and efficiency, such as models with head phones, and those that allow numerous call waiting and messaging to permit the advisors to return calls during less busy times.
- The counselors are medical doctors but feel they need more enhancement of their skills particularly to do the psychosocial counseling, this is a very difficult area to deal with and not in their normal repertoire.
- The counselors require more RH training and a question/answer guide to help them to supply accurate information to the wide range of possible questions.

Youth Information Centers and Peer Education

Since 2009, the YIC have trained approximately 300 per year or a total of around 1,200 peer educators (Y-peer) using a peer education manual specifically developed for the local context. These peer educators in turn, engage other youth in discussions about Adolescent Sexual Reproductive Health (ASRH) issues, seeking to promote health-enhancing knowledge and skills. The assumption is that familiar people, giving locally relevant and meaningful suggestions, in appropriate local language and taking into account the local context, will most likely be able to promote health-enhancing behavior change, but this assumption should be tested. Some youth lead organizations also attend the Y-peer ToT and conduct the same training for youth peer groups; HIV and SRH is part of the Y-peer training curriculum.

The UNFPA-supported Youth Information Centers were reduced to only one functioning center in Kabul in 2012-13. According to interviewees, the development of the centers was not backed by a good strategic plan with proper buy-in from the Deputy Ministry which was not effective in its role in mobilizing youth in the provinces to use the centers, or creating a “youth-driven” environment and reporting on results. Thus, despite substantial investment in infrastructure and staff, the centers were not seen as producing outcomes as desired. UNICEF also closed similar centers citing difficulties in monitoring the inputs and outputs. The remaining functioning center operated by AFGA in Kabul continues with the Y-peer training. Nevertheless, according to youth who participated, the youth information centers were beneficial spaces for youth who took their own initiatives to promote knowledge sharing through presentations and discussions. The concept of comprehensive integrated youth centers should be considered in Afghanistan to address all aspects of youth problems: the youth centers should act as an employment placement center where they can come and register their skills and qualifications and is matched with, for example, labour market information systems, Youth education and TVET, Youth in the Defense Force, Youth in Agriculture, Youth in Health (Youth Friendly services and counseling services – helpline); Youth in Sports, and Youth Volunteer schemes.

The Y-peer female educators testified as to their high level of confidence in imparting SRH information to their peers and use any opportunity to do so now as they will in the future. They feel capable of advising their peers on how to talk to their parents about their future. Challenges to the peer counseling include:

- The training is only 6 days after school and the materials are not covered in depth, the students request more emphasis on the RH information, e.g. the reproductive system, while the teachers would like to include more on basic life skills such as information on forced and early marriages.
- Training modules are needed, they have only an assortment of videos and pictures.
- Most emphasis for the Y-peer is on urban areas and more resources need to be extended to the rural areas.

The following testimonials are from a focus group discussion with nine girl peer counselors in Kabul, aged 17, all of whom intend to pursue professional careers, for example as doctors, lawyers and teachers.

I chose to become a peer counselor because I believe that doing so will strengthen my skills that I will need to become a lawyer, and I feel that this has been successful; I can take information and transform it into advice for my peers that helps them in their daily life.

I grew up in Wardak Province in the countryside and moved to Kabul last year. As a teenager, I had no one to turn to with my questions about becoming an adult and sexual reproductive health, these were taboo subjects. So I welcome the opportunity to gain knowledge and to share it with others who are eager to learn since this occupies our daily thoughts about our bodies and what we will do to plan our future with marriage and children.

4.1.4 Efficiency

In 2012, the CO mobilized USD 18.9 million of which 93% was implemented in a country in-conflict with a deteriorating security situation. In total, a projected \$39 m was available for the CP3, 2010-2014. While it is important that youth themes are factored into the programmatic areas, funds for youth should be recorded separately in terms of budget so that the percentage of dedicated funds can be determined.

The chart below indicates the actual spending on the youth-specific activities, approximately \$1.3 m which comprises less than 3.5% of the CO budget. It is noted that approximately 50% of the planned youth budget dedicated to teacher training was not used due to issues in obtaining partner support such as from the Ministry of Education; this represented a serious loss of momentum in achieving the CPAP goals on ASRH and youth development. These funds need to be applied to the remainder of the CP3 or carried forth to CP4.

A fund raising strategy for youth activities is needed to support effective programming and is likely to produce significant funding results. More emphasis is needed to focus on uncovered or less covered youth themes such as child marriage, prevention of adolescent births and other categories of youth, particularly drug users. Much more can be done through training for health workers particularly the Community Midwives.

Table 3. ASRH and Youth Budgetary Allocations 2010 to 2013

	PDS	ASRH	Total
2010	77,603 USD <i>YAP, consultations, capacity building</i>	176,063 USD <i>AWP with DMoYA, YICs, Youth Peer Programme</i>	362,260 USD
		108,594 USD <i>AWP with MoPH Integration of ASRH into BPHS</i>	
2011	77,402 USD <i>AWP DMoYA policy development and capacity building</i>	266,651 USD <i>AWP with MoPH & DMoYA</i>	420,535 USD
		76,482 USD <i>AWP with MoE Curriculum Review</i>	
2012	140,011 USD (63,500 from Sweden) <i>AWP DMoYA</i>	191,850 <i>AWP with MoPH & DMoYA YICs, YFS training</i>	331,861 USD
2013	113,985 USD <i>DMoYA: Policy, Intl' Consultant, Youth Assessment Survey; YAP</i>	125,252 USD <i>MoPH YIC and YHL</i>	191,387 USD
	Total Projected Youth Budget 2010-2013		1,306,043 USD

Youth health line operation is relatively efficient with minimal infrastructure and staff, however, it serves a limited number of clients, likely to be youth in schools and in urban settings, although this requires verification. Even if positioned in the provinces the health line may not be successful in reaching youth living in rural and remote areas, unless support is provided for youth to call the line, such as access to phone service and phones. Further, follow-up is difficult to ascertain whether counseling was effective, such as whether KAP were changed.

Comparatively, the youth information centers were perceived by some interviewees as being capable of serving larger numbers of youth with greater outcomes and results, providing tangible feedback to management, staff and peer counselors. The long term effects of peer counseling might be considered to be the training of influential youth, notably those who complete high school and go on to higher education and professional public careers, thus ultimately influencing policy and attitudes in the country. An evaluation is needed to assess what the issues were in operating the centers, what objectives were achieved and which were not achieved, what benefits they served, and in particular to substantiate the investment in the centers.

4.1.5 Sustainability

In 2011, UNFPA successfully advocated for inclusion of ASRH into the Basic Package of Health Services (BPHS). This may contribute to sustainability depending on the continuing support for the BPHS to become an Afghan-managed system. An assessment of health facilities has been carried out so as to provide youth friendly services. UNFPA is advocating for national budgetary allocations for youth but funds have not yet been allocated. The government is requesting that more donor funds be contributed directly to the Ministry of Finance for disbursement to the ministries.

UNFPA conducted numerous capacity development activities in CP3. In 2011, the capacity of the Department of Child and Adolescent Health, MOPH, Department of Curriculum Development, Ministry of Education and the Deputy Ministry of Youth, was enhanced to provide youth friendly services. A Resource Centre has been established with the Deputy Ministry of Youth Affairs, to enhance the central government's capacity to respond to the needs of Afghanistan's youth. In 2012, the institutional capacity of the Child and Adolescent Health Department of the MOPH and the implementing partner AFGA has been strengthened to provide youth friendly services. Skill enhancement of health service providers has been carried out, although the degree to which was implemented needs to be ascertained. The impact of this training on the on the provision of health services to youth should be assessed.

The CP3 outcome for incorporation of ASRH issues into the national curriculum was not followed through to completion. However, the dialog with the Department of Curriculum Development has now been resumed regarding the implementation of this activity.

Sustainability may be effectively pursued through the youth networks and community based organizations, but the support for their capacity development has so far been limited. In total, three participants from Afghanistan (a youth-led organization) took part in TOT training in Bangkok, Thailand, including two female participants. Based on training and active participation they were able to receive a small grant to implement two days training on SRHR, Gender Equality and Advocacy Skills. This training was organized in a Kabul youth information center for more than 20 young people. Youth networks are very active in Afghanistan and youth are very motivated and require relatively little support to create a multiplier effect, yet youth have difficulties accessing opportunities and need facilitation such as by the UN to access the compounds so that they can present their ideas. Supporting youth networks to help address youth bulge issues may be a major key to long term sustainability.

In preparation for the shifting of capacity to the government, IPs should prepare exit strategies which ensure that handover will be efficiently carried out. In the CP3 evaluation workshops in Bamiyan and Kabul, participants asserted that technical assistance should ensure the capacity strengthening of national counterparts and that technical advisors should not be performing their tasks in isolation but with coaching and mentoring. The following matrix indicates the youth table's response to needs for sustainability.

	Sustainability, what is needed to ensure local capacities in program implementation for long term viability of the Youth programme
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1	Capacity building of local communities' institutions
2	Long term vision and intervention
3	Advocacy (2 dots)
4	Ownership (1 dot)
5	Involvement of stakeholders (youth, local community, etc.) in programme and policy design and implementation
6	Promote available local resources and their utilization.

4.1.6 Management: Partnerships

Although a number of project objectives have been partially or fully achieved throughout CP3, UNFPA's youth focus could be much more unified to promote effectiveness and efficiency. The UNFPA Afghanistan CO has been selected as one of three countries which will implement the global 2013 five pronged strategy (described above) through the cluster approach to aid the cross cutting of youth-related issues through the other programmatic areas. The first step in implementing the Youth Cluster is to create and document a new youth unit as this was not reflected in the AWP 2014.

The CP3 Evaluation Kabul workshop (September 2013) working table on youth (government, NGOs and UNFPA) noted weak coherence and coordination as major weaknesses. Within the CO:

- The fragmentation of the youth support theme among the PD, Gender and RH results has not appeared to strengthen the outcomes, rather the youth theme has tended to become marginalized against the larger or more visible projects in RH, such as the FHH, and PD such as the CSO surveys.
- The youth focus appears as a group of separate activities rather than part of a strategic approach to addressing the problems of adolescents and youth.
- Youth concerns may be integrated on paper but in practice are not always well integrated into the programmatic areas, e.g. the FHH does not have a specific strategy for addressing concerns of ASRH in the community. The Bamiyan SDES while identifying numbers of youth and other statistics does not integrate the youth demographic concerns in the country by highlighting findings on youth in the province.
- It is unclear how the youth and gender activities overlap or complement each other and whether there are specific targets for youth, for example, in regard to training, other than several youth representatives in the provinces. Unifying themes may be to intensify focus on integrating child marriage and preventing early pregnancy across gender, RH PD and youth.

Coordination with external stakeholders. There is evidence that reaching out to coordinate with other stakeholders investing in youth has paid off, some funding was received from USAID for joint activities. The level of cooperation and coordination among agencies assisting with the focus on youth require strengthening. Cooperation has been mainly piecemeal and fragmented and cooperative and collaborative relationships should be elaborated in a programmatic strategy.

Monitoring and evaluation. The distribution of youth empowerment and SRH activities among the RH and PD programmatic areas on the results matrix make them somewhat challenging to evaluate. It is difficult to ascertain whether the youth participation in RH, PD and GE activities was monitored as a population of concern.

4.2 Humanitarian Assistance

4.2.1 Objectives and Activities

UNFPA's global humanitarian assistance policy

UNFPA offers a number of services before during and after emergencies to protect the reproductive health of communities in crisis. These include working with partners to ensure that the specific needs of women are factored into the planning of all humanitarian assistance, and considering urgent reproductive health needs that are sometimes forgotten. The Minimum Initial Service Package (MISP) for Reproductive Health (RH) is a priority set of life-saving activities to be implemented at the onset of a humanitarian crisis. The programme is designed to address the reproductive health needs of populations in the earliest phases of emergencies in order to:

prevent and respond to sexual violence; prevent excess newborn and mother illness and death; reduce HIV transmission; and plan for comprehensive reproductive health services.

UNFPA helps to strengthen countries' ability to respond effectively with a focus on the integration of the MISP into national emergency preparedness plans. In addition, UNFPA aims to strengthen the capacity of coordinators in the region as trainers and support trained national institutions in advocating for the inclusion of the programme into national contingency plans. The Fund also supports various data collection activities, including censuses to provide detailed information for planning and rapid health assessments to allow for appropriate, effective and efficient relief. UNFPA also supports the interagency GenCap initiative, which deploys gender advisors on short notice in the initial stages of sudden-onset emergencies as well as in protracted or recurring humanitarian situations.

UNFPA's Humanitarian Assistance Response in Afghanistan

The CPAP 3 outputs by programmatic area are:

a) Population and Development Strategy Outcome and Output:

Outcome-1: by 2013 increased utilization of socio-demographic data for evidence-based decision-making and policy and programme formulation and monitoring in the support of the ANDS, at national and sub-national levels.

Output 1.1: Improved availability and use of national and local data, disaggregated by sex and age, to formulate, implement and monitor policies and programmes

b) Reproductive Health Outcome and Output:

Outcome-1: by 2013, utilization of high-quality reproductive health information and maternal health and family planning services is increased in selected underserved province.

Output 1.2: Strengthened capacity of health facilities and service providers, with a focus on selected provinces, to provide antenatal and post-natal care, basic and comprehensive emergency obstetric care and fistula treatment

c) Gender Outcome and Output:

Outcome-1: By 2013, an environment conducive to empowering women and eliminating gender-based violence is created in target provinces.

Output 1.2: Enhanced capacity of target communities to identify opportunities for women's involvement in family and community life, and to prevent, respond to and monitor gender-based violence.

The CP2 evaluation (2010) urged greater attention to UNFPA's mandate for humanitarian assistance as part of the PD. In 2011, UNFPA received funding from the Danish Government for 'Improving Disaster Preparedness and Response in the Central Highlands of Afghanistan', to be implemented with partners, the Ministry of Public Health (MoPH), Central Statistics Office (CSO), the Agency for National Disaster Management in Afghanistan (ANDMA), and the Agency for Assistance and Development of Afghanistan (AADA).⁵⁰

In 2012, UNFPA supported the MoPH through capacity building of Emergency Preparedness and Response (EPR) department staff and Reproductive Health staff through a Minimum Initial Service Package (MISP) training of trainers (ToTs). The health care providers who received ToTs in Kabul conducted MISP trainings for provincial staff in Badakhshan and Daikundi provinces. A total of 20 health care providers from MoPH and BPHS implementing organizations participated in the MISP ToT and 54 provincial staff received MISP training in 2012.⁵¹

In 2013, UNFPA in collaboration with the MoPH carried out the Sexual Health Program in Crisis and Post-Crisis (SPRINT) training, an AusAID initiative, in Bamiyan for 20 participants and in Faryab for 22 participants.⁵² In 2013, UNFPA signed an AWP with ANDMA using Danish funds for development of district disaster plans in 8 districts of Bamiyan and Daikundi. The activities planned July-December 2013 include preparation of District

⁵⁰ Danish Project Progress Report for Embassy of Denmark, Kabul Afghanistan, 2011, and Progress Update of December 2012 to June 2013.

⁵¹ UNFPA Afghanistan COAR, 2012

⁵² MISP Training reports, UNFPA and MoPH, Provincial Public Health Office, Bamyan Province, July 2013; Faryab Province, September 2013; First Quarterly Report for January to April 2013; Second Quarterly Report, May to August, 2013.

Disaster Preparedness and Response Plans, development of training materials, training of 1600 volunteers, preparation of district data bases and establishment of disaster preparedness and response teams.⁵³

In 2013, UNFPA handed over Emergency Reproductive Health Kits procured with UNFPA Emergency Funds to Kandahar Public Health Department in mid-July 2013, and to Surubi Hospital in Kabul Province using CERF funds, as well as for other provinces right after natural disasters. Dignity kits (with personal hygiene items) were also positioned in UNFPA-served provinces. In 2013, the Youth Health and Development Organization (YHDO) was contracted to support development of district disaster management plans in Bamiyan and Daikundi with accompanying training and formation of disaster management teams.

4.2.2 Relevance

The ANDS promotes development of preparedness measures and rapid response to humanitarian emergencies to protect vulnerable people, in particular the poor, refugees, returnees and IDPs. Afghanistan is frequently affected by natural disasters, including earthquakes, droughts, floods, landslides, extreme weather conditions including avalanches and sand storms that adversely affect the lives, property and livelihoods of Afghan people. Earthquakes are relatively frequent, especially in the north and northeast, and often trigger landslides. Flooding is common in the spring when snow begins to melt and rainfall is heavy. Afghanistan has also experienced prolonged periods of drought.

UNFPA's humanitarian assistance work is directly linked to the UNDAF outcome: *Improved capacity to manage natural resources to support poverty reduction and dispute resolution, and to reduce vulnerability to natural disasters*. In a recently published report, the presence of conflict was shown to increase the vulnerability of marginalized populations to natural hazards, in part due to exposure to a complex set of recurrent hazards that combine to reduce the asset base of families and undermine the government's ability to provide security and services, as well as the international community's ability to maintain emergency and development programmes in insecure areas. The report rates Afghanistan high in a composite ranking of fragility, conflict, disaster risk, levels of poverty and vulnerability to climate change - only Somalia was rated higher.⁵⁴

In the conflict and disaster-prone environment, UNFPA's support for developing national capacity to provide RH in emergencies is particularly relevant. (See response to the Surubi Flood Disaster in the box below.) The MISP for RH is a set of priority activities which conform to international standards set by the *Sphere Humanitarian Charter and Minimum Standards in Disaster Response*. As demonstrated in other countries, when the MISP is implemented at the onset of a crisis, it saves lives and prevents illness, helps prevent sexual violence and provide appropriate assistance to survivors by ensuring systems are in place to protect displaced populations, particularly women and girls, and ensuring that medical services, including psychosocial support, are available.

Relevancy has been somewhat adversely affected because the National Disaster Management Plan, under the direction of the Afghanistan National Disaster Management Agency (ANDMA), has not effectively integrated RH or GBV. In addition to the national plan, there are provincial plans for two provinces; Herat and Kunduz, which also do not integrate RH or GBV. As of the 2010 COAR, the SRH needs of youth had not been incorporated into the national disaster preparedness plan. However, with the Danish funding in 2013, UNFPA can work with ANDMA to influence the development of district plans for eight districts. This presents an opportunity to advocate for updating the national plan and any district plans that do not address, RH, GBV and youth.

4.2.3 Effectiveness

The Humanitarian Assistance (HA) is a transversal component, aimed to create synergy among the programmatic areas for emergency preparedness and response and attention to other humanitarian needs. In 2011 the HA focused on: (a) Provision of technical support on integration of psychosocial support and GBV response into community health care provision in Daikundi and Bamiyan provinces. (b) Interventions to build capacity of health care providers in Kabul Pul-e-Charkhi Prison. (c) Strengthening of community resilience in public health, establishing of FHH, and training of CHWs (d) Strengthening national and sub-national capacity

⁵³ Agreement between UNFPA, ANDMA, and YHDO, July 2013.

⁵⁴ Katie Harris, David Keen and Tom Mitchell, 2013 When Disasters and Conflict Collide - Improving Links Between Disaster resilience and Conflict Prevention, ODI, February (cited from the draft CCA, September 2013)

for emergency preparedness to address RH and gender concerns in natural disasters and post-emergency situations.

Output1.1: Improved availability and use of national and local data, disaggregated by sex and age, to formulate, implement and monitor policies and programmes

Based on the work done by CSO with support from PD, the SDES has collected data on categories of the population with varying types of vulnerability. Among the special groups are people with disabilities, youth and women. Their demographic and socio-economic attributes require special treatment in policy and programme terms, which must be factored into the country's disaster management and development plans and processes at all levels. SDES includes a mapping and listing of all houses, business establishments and institutions at the district and village levels as well as the location of various types of community infrastructure, such as health facilities, schools, mosques, markets and roads, which is essential for emergency preparedness plans that are required to prevent or mitigate widespread devastation in the event of a disaster. The data categorizes population groups by sex, age, education, literacy, employment status and other important variables that can help shape humanitarian assistance if ever needed.

The SDES data will be used to create disaster management plans and relevant training for eight districts which is now in process. While this effort is an excellent example of synergies among the programmes, it must be noted that it is addressing a small part of the need for district preparedness. In order to be more timely, the newest SDES information should be expeditiously used in similar exercises.

Output 1.2: Strengthened capacity of health facilities and service providers, with a focus on selected provinces, to provide antenatal and post-natal care, basic and comprehensive emergency obstetric care and fistula treatment

Output 1.2: Enhanced capacity of target communities to identify opportunities for women's involvement in family and community life, and to prevent, respond to and monitor gender-based violence.

The RH MISP training programme for Bamiyan and Daikundi was effectively designed. The UNFPA humanitarian assistance expert provided technical assistance and MoPH staff also facilitated. The objectives were to: a) increase access to sexual and reproductive health (SRH) information and services for people who have survived crises or are living in a post-crisis situation; and b) increase the capacity of the BPHS implementing organizations and MoPH staff to implement the MISP for SRH in crisis situations. The topics covered were the MISP, SGBV, maternal and newborn health, HIV/STIs, and monitoring and evaluation.

An MISP manual was used to facilitate. A post assessment of the workshop indicated that the participants had high interest regarding the topics of the training and all sessions were very participatory. The appropriate methodology was used for each topic of the training, among them were: presentation/lecture, group discussions, brain storming and, role play. Although the workshops were evaluated by participants at the end of the training, later follow-up is needed to determine effectiveness.

4.2.4 Efficiency

In the 2011 AWP, \$175,000 was allocated for emergency preparedness planning with the MoPH. The Danish Government donated approximately \$1 m from 2011 to 2013. In 2011-12, these funds were spread over a number of programmatic areas while they are more focused now on the planning aspects for districts. UNFPA also received USD 414,090,000 from CERF in April 2013. This fund will be used to procure and preposition RH and Dignity kits, and build the capacity of MoPH central and provincial staff; and BPHS implementing organizations in order to build response capacity in 34 provinces.

Table 4. Financial Statement as of 21st July, 2013- (UNCERTIFIED), in USD

Donor	Year	Opening Balance	Contribution	Expenditure	Fund Balance	Execution Rate
		A	B	D	E= (B-(C+D))	

Delivery of Emergency Reproductive Health Kits to Flood-Affected Surobi District

On 3 August, 2013 heavy rains resulted in flash floods and high levels of water in 13 villages of Surobi district of Kabul Province. A joint rapid needs assessment was carried out in four villages by the ANDMA Kabul, DoRRD, IOM and ARCS. In light of the large area to cover and inaccessibility due to insecurity, the remaining nine villages were assessed the next day.

As of 4 August, according to the District Disaster Authority (DDA) and IOM, 42 people died, 426 houses were completely destroyed, 832 livestock were washed away, 600 acre land were badly affected, 27,120 fruit trees and 2110 meter protection wall were completely destroyed. In addition, four mosques were damaged or destroyed; four schools (two girls and two boys) were destroyed or damaged; and, the Surobi 20-bed hospital was flooded and the surrounding wall collapsed. The emergency room was cleaned and was able to receive patients.



UNFPA delivered RH Kits to Surobi Hospital one week after the Hospital was smashed by a flood

1. Coordination prior to the delivery of RH Kits:

After the flood demolished most parts of Surobi district including the district hospital, the Emergency Preparedness and Response Department of MoPH and the Health Cluster asked UNFPA to provide RH kits for Surobi District Hospital in order to re-operationalize the maternity ward of the hospital. Before delivering the RH kits, information was collected about the population in the catchment areas of the hospital, including the number of deliveries per month. Based on the collected information and with consultation of MoPH/EPR department, the number of kits to be delivered to the hospital was determined.

2. Delivery of RH Kits to the hospital:

The RH kits were recently procured and were under custom clearance process in the Kabul International Airport custom clearance office, when the flash flood smashed the eastern district of Kabul province. After releasing the reports of rapid assessment, UNFPA senior management approved to deliver the following RH kits to Surobi Hospital. On 13th of August, the RH kits were delivered while the Minister of Public Health was also visiting the hospital.

ITEM ID (from Atlas)	DESCRIPTION	QUANTITY
Kit No.1A	Male Condom	1
Kit No. 1B	Female Condom	1
Kit No. 2A	Clean Delivery Kit, Individual	1
Kit No. 2B	Clean Delivery, birth attendant	2
Kit No. 5	Treatment of Sexually Transmitted Infection (STI)	1
Kit No. 6A	Clinical Delivery Assistance kit - Reusable Equipment	1
Kit No.6B	Clinical Delivery Assistance kit- Drugs and Disposable Equipment	1
Kit No.7	Intra Uterine Devices (IUD Kit)	1
Kit No. 8	FINAL - UNFPA Regional Office for South Asia - Procurement and Programmatic Support Division – FINAL submitted Dec 29 2013	1
Kit No.9	Suture of Tears and Vaginal Examination kit	1
Kit No.10A	Vacuum Extraction Delivery kit (model HM Healthcare)	1
Kit No.11A	Referral Level Reusable Equipment kit	1
Kit No.12	Blood Transfusion kit	1

Denmark-DKA24	2013	488,646	488,646	241,219	247,427	49,4%
CERF FUND	2013	414,089	414,098	289,024	125,074	70%
Total		902,735	902,735	530,243	372,501	

The funding for HA has helped tremendously to boost district planning and preparedness. However, given the urgent needs for disaster response plans and training, the funds need to be expeditiously spent. Delays in selection of a consultant organization for implementation of the project took more than the expected time, causing delays in the actual project implementation. On the positive side, a cost savings was realized through the open bidding process allowing expansion of the effort to four more districts of the two provinces. The expansion will take an additional 4 months to complete and a no cost extension was requested of the Danish government. Although Sweden is another potential donor for humanitarian assistance and disaster risk reduction, there is appropriate caution regarding the capacity of the office to efficiently manage the use of the funds with current staffing.

4.2.5 Management

In the CO, the unfilled Deputy Representative position has affected the functioning of all programmatic areas as mentioned before; the Humanitarian professional staff (currently one staff member) reports directly to the Representative who has to devote his time to also covering the Deputy Reps duties. A “cluster” for Humanitarian Assistance has been started in the CO to promote broader consultation for planning and monitoring. As funds are drawn down for the district planning exercises, adequate staff time should be allocated to monitoring the inputs and outputs/outcomes.

The internal review of CPAP indicators (January 2013) points out that there is no result area that directly addresses humanitarian assistance, although Afghanistan is notably a country in transition and that post conflict and humanitarian assistance is a focus of interventions. Humanitarian assistance requires its own results area as well as being a cross cutting output area. There is only one explicit indicator, under Output 1.2 - # of district administrations in selected provinces that have an emergency preparedness plan available that integrates RH and GBV. Indicators are needed for other aspects of emergency preparedness such as pre-positioning of RH and dignity kits and humanitarian policy level results areas.

Several government ministries, UN agencies and national and international NGOs have been working together to deal with disaster-related issues. The CO participates in a number of UN coordination mechanisms for humanitarian assistance, on the UN Humanitarian Team (UNHT) including the development of the Common Humanitarian Action Plan (CHAP) and Civil Protection.

4.2.6 Sustainability

The National Disaster Management Plan is currently under revision and ANDMA is working with a number of donors and assistance agencies including UNFPA who are advocating for more inclusion of gender-related issues such as RH and GBV in the national disaster management and preparedness policy. ANDMA functions under the Social Protection aspect of the ANDS and has devoted attention to ensuring that women receive priority in search and rescue operations at the provincial and district levels. Examples of recent disaster casualties indicate that the deaths of women and children have decreased relative to the total number of deaths. For example, in the Surobi flood, of 42 deaths 11 were women and children. UNFPA’s work with the police is helpful in promoting a greater focus on the vulnerability of women as police are in the direct chain of command for disaster response. More work on police awareness will be beneficial to women in disasters.

ANDMA does not have staff at the district level and having at least one person in the district would help considerably with preparedness and foster sustainability. ANDMA does not have sufficient resources or capacity to have a presence at the district level and is currently dependent on assistance agencies to support their Emergency Operations Center and provincial/district based NGOs to structure disaster preparedness and response; the NGOs have sponsored workshops to exchange experiences countrywide. In regard to community preparedness, the communities are the first responders and have their own methods for clearing avalanches,

etc. and ANDMA is cautious that having district plans will not detract from but rather support the preparedness of communities.

UNFPA's assistance with district level planning has the potential to contribute to district disaster management capacity. Training is being provided by a national NGO (YADO) in tandem with the development of district disaster management plans for the District Disaster Agencies and communities. UNFPA's agreement with IP ACTED is to support the IP to provide logistical and financial services to support the training. The basic model of contract used by UNFPA does not stipulate the objectives for transferring skills and knowledge to the government and other national actors, this is implied rather than explicit and the contract mainly focuses on deliverables from the contractor. Changes in KAP are not included as objectives or for follow-up. The contract also does not stipulate how GBV and FH will be incorporated. Contracts need to contain assurances of capacity transfer especially to government staff who will be responsible for institutionalizing, monitoring and updating the plans.

Chapter 5 Analysis of Programmatic Areas

– Population and Development

– Gender Equality

5.1 Population and Development

5.1.1 Objectives and Activities

UNFPA's global focus on population and development aims to eradicate poverty and achieve sustainable development by supporting the governments in gathering information about, and track and analyze population trends, developing sound policies and generating the political will to address both current and future needs. Based on its mandate in population and development, UNFPA assists countries in developing capacity in data collection and analysis, and promotes their participation in national, regional and global policy dialogue. This section covers mainly UNFPA's support to the Central Statistics Organization (CSO).

The **CPAP 3 outcomes, outcome indicators, output and output indicators** related to population and development activities are as follows.

Output 1.1: # of policies formulated based on disaggregated data

Output 2.1: # of planners, policy-makers and decision-makers at national and sub-national levels with the knowledge and capacity to use data for planning policy making and decision-making

Output 3.1: SDES data collected, tabulated and made accessible

Output indicators:

- Training, Research and Information facility on Population and Development (TRIPOD) established and operational
- # of selected national government institutions and district administrations with skilled staff and tools to collect and analyse data, and disseminate socio-economic and demographic information
- Socio-economic, geographic and demographic information system for emergency preparedness and response in place

Outcome: By 2013, increased utilization of socio-demographic data for evidence-based decision-making and policy and programme formulation and monitoring in support of the Afghanistan National Development Strategy, at national and sub-national levels

Outcome indicators:

- The socio-demographic and economic data collected and processed, results published, analysed and disseminated
- # of central government institutions, their provincial directorates, and district administrations, that practice evidence-based planning
- # of sectoral plans based on disaggregated data by sex and age

Activities, Outputs and Outcomes/Results (See “expected versus actual” results matrix in the annex)

The County Office Annual Report (COAR) 2012 reported the following activities:

- Since 2010 UNFPA has supported CSO in building its capacity to plan, collect, process, analyse and disseminate data through the conduct of the trainings inside and outside the country and to pursue more efficient work on the GIS and electronic data processing
- UNFPA provided technical support to CSO to conduct the Socio-Demographic and Economic Survey(SDES) at provincial level
- UNFPA supported the Government of Afghanistan through preparation of Population Situation Analysis (PSA)
- Technical support that was provided to the provincial statistics offices in three provinces of Bamian, Ghor and Daikundi consisted of equipment and training.

5.1.2 Relevance

UNFPA's support to CSO through the PD programme is well aligned with the country's need for availability of population data at the smallest geographical units for local development planning and resource allocation. To date, the most comprehensive information comes from a population and housing census more than 30 years old which was incomplete in parts. In 2008, preparations for a country wide census had been made when the government postponed it indefinitely citing security issues and weak political will in some provinces. Given the vital need for population data by the government and the international community, particularly for planning services and development and humanitarian programmes, the alternative solution for filling in the gap was to conduct a socio-demographic and economic survey (SDES) in each province disaggregated by gender and age through 2016.

One constraint concerning results based planning is the need to monitor and assess progress based on development indicators, however, the actual denominators are largely missing or based on extrapolation, so the programmes cannot be accurately judged in terms of results areas. The SDES should be useful for monitoring the implementation and progress toward the ANDS, MDGs, as well as for the design of next UNDAF.

"When we need to know, for instance, the level of poverty among the population disaggregated by age and sex for planning purposes, CSO is the first place we refer to. But, what we get from the CSO is estimated figures based on a 30 year old census...we need updated and accurate data." Ministry of Economics

The CPAP has set out a key outcome concerning increased utilization of the data analysis, not merely its collection and analysis. Relevance has been weakened somewhat by debates over data collection coverage in the Bamiyan SDES (described in more detail below). Some organizations citing frustration with lack of agreed data collection approaches prefer to use their own data collection systems instead of building the capacity of the government; this parallel approach has been demonstrated over time and in many countries as not sustainable. Thus, UNFPA's work with CSO continues to be appropriate in the context of national development but all partners need to ensure that the utility feature of the strategy is monitored and steered to produce greater satisfaction from users.

5.1.3 Effectiveness

UNFPA's technical and financial support enabled CSO to update the Afghanistan household listing in 2010, and to conduct the SDES Bamiyan in 2011 and in Ghor and Diakunki in 2012-2013. UNFPA and CSO continued to build CSO's institutional capacity at national and sub-national levels, and securing funds for running the SDES in four other provinces (Kabul, Parwan, Kapisa and Panjsher) in 2013 and 2014.

The major challenges for conducting such surveys are the security situation, geographical makeup of the provinces, logistics, means of payment of the enumerators, and most importantly difficulty in finding a number of qualified (having the basic knowledge of reading and writing) men and in particular women as enumerators, editors, district statistics officers and controllers in those provinces. Due to the cultural norms in Afghanistan, females should be interviewed by a female; otherwise, women in the households cannot present themselves in front of male enumerators. The CSO provincial offices and UNFPA tried their best to recruit female enumerators by holding frequent meetings with community shuras, religious leaders, and community elders but the major challenge was the low level of literacy among females in those provinces resulted in not finding enough number of qualified females. On the other hand, for the sake of survey's validity and reliability, the selection criteria cannot be lowered. Despite all efforts, at the end of recruitment of the field staff there were for instance, only 50 female surveyors in Ghor province compared to more than a thousand male enumerators.

Data use is a major challenge in the country where no updated data were available for decades. Although the Bamiyan SDES highlights were shared with stakeholders and parliamentarians through a workshop and presentations and some workshops conducted to some government departments and media on how to properly utilize the available data, but access to the data analysis and raw data was not always user friendly according to some interviewees. Therefore, more strategic measures should be taken into practice to make data user friendly for evidence-based decision making at national and sub-national levels by conducting workshops, seminars and use of mass media.

a) Afghanistan Household listing

The Afghanistan household listing which was generated in 2006 and, updated in 2010 provided reliable data on the number of villages and households. These data will be used as inputs for mapping of enumeration areas required for the socio-demographic and economic survey (SDES). Currently, this list is being used by CSO as a sampling frame for other household surveys such as the National Risk and Vulnerability Assessment (NRVA) survey, and the Extended Programme on Immunization (EPI) survey.

b) The Socio-demographic and Economic Survey (SDES) in Bamiyan

The SDES in Bamiyan was conducted in 2011. Data on population structure, education, employment status, fertility and mortality rates, and household composition and housing structure were gathered, and disaggregated by age and gender. The highlights of the survey were shared with the stakeholders in a workshop at the central and sub-national levels. However, due to disagreement by some Bamiyan provincial authorities with the primary findings, the final report has not been fully disseminated in Bamiyan province. This issue caused a delay both in effective communication and bringing up a common consensus on the findings, as well as in use of the data for evidence-based decision-making processes at the provincial and district levels.

“If we had access to the full report of Bamiyan SDES, we would definitely defend the extensive efforts invested while conducting the SDES in Bamiyan and its validity with the governor and other officials who opposed the findings.”
PSO Bamiyan

Based on the CP3 evaluation workshops in Bamiyan and Kabul, the Bamiyan SDES was the first large joint field operation for both CSO and UNFPA, thus some shortcomings could be expected in terms of logistics and field operation. Unfortunately, administrative problems were blamed and used as a point of argument over the validity of the findings. Payment issues for enumerators and controllers, for instance, were featured in arguments. The payment structure was not transparent or announced upon recruitment and payment for some took 7 months to a year. However, to some extent, problems could be explained by unavailability of bank branches at the operation sites, geographical conditions, weather conditions, delay or failure of submission of minimum required supporting documents by the payees, and in some cases untrue claims for overtime work; these issues were taken up with the governor's office.

c) The SDES in Ghor and Daikundi

The SDES data was collected in Ghor and Daikundi from September 2012 to January 2013. Data entry for Daikundi was conducted in the provincial capital while for Ghor the data from half of the districts were entered in Ghor and the remaining in Kabul. An international data processing expert, hired by UNFPA, is working on the data processing aspect of the survey. The highlights of the survey are expected to be released by the end of 2013.

d) The SDES in Kabul, Parwan, Kapisa and Panjsher

The unstable political and security environment in Afghanistan were major challenges for both CSO and UNFPA in implementing planned activities. UNFPA received funds from DFID and the Embassy of Japan for conducting SDES in four provinces (Kabul, Parwan, Kapisa and Panjsher) in 2013 and 2014. However, the governor of Panjsher did not permit CSO to conduct the SDES in that province after release of funds. Now, the challenge is to continue the negotiations with the Panjsher governor, or wait for the new governor who will take over after 2014 presidential election. It is possible that earlier consultations may have been preventive.

e) Capacity Building

UNFPA has provided technical and infrastructural support for CSO for more than 10 years. After decades of war and losing most of its trained, committed and motivated personnel as well its physical infrastructure, CSO received technical and financial support from different donors but in particular from UNFPA. UNFPA has supported the infrastructural and technical capacity improvements in the CSO that are more obvious than strategic directions for its development. It is noteworthy that some departments of CSO can operate effectively

by themselves without help of external experts (such as the GIS and printing press units), whereas some other departments still require technical assistance from international consultants hired by UNFPA.

The CP2 evaluation placed emphasis on building human resource capacities by mentoring and coaching of national staff, rather than hiring international consultants for meeting contractual deadlines. Furthermore, the CSO national staff who were involved in and conducted the census in 1979 was not given more space to use and share their considerable expertise. A number of interviewees recommended that CSO undertake a capacity assessment to better direct and consolidate efforts and funds to efficiently and effectively build institutional capacity and not lose the gains already made. The CSO coordination and training department, has developed a strategy with UNDP for capacity development, but they lack consultancy services to support this plan especially in the provinces.

A roster of trained personnel and a database for the trainings are not available either in CSO or UNPFA, having such recording system helps to track those received trainings and the type of the training. Then, they can tailor the next level of the trainings for the staff. A roster of enumerators will serve as a reference for recruiting those trained male and female enumerators for the next surveys.

f) Interventions with Parliamentarians

UNFPA has promoted advocacy and dialog with parliamentarians at the national level and it is based on signed MOU with the service provider and provides them with equipment and office facility, and supplies parliamentarians with capacity building on gender and professional training on legislations and draft writing of acts /law in the country or abroad. Exposure trips are provided for parliamentarians to build relationship between other parliaments, such as in the in IPU (Inter -parliamentarians Union) annual meeting in Geneva. UNFPA has shared the Bamiyan study summary report and sought feedback and reaction of PMs toward the results.

UNFPA approaches parliament a route of advocacy for bringing attention to the importance of availability of population data and use of data. It is too early to measure its impact for increased national advocacy for PD through parliamentarians. However, the parliamentarians' provided some feedback saying that the UNFPA training on gender was effective especially for female parliament members. Now, women have their own caucus to back up their opinion, ideas, and statements in the parliament open sessions. Men in the parliament have stronger position connected to any of political parties individually or as a group, while compared to them, however, the female position is fragile and weak. Women need the supporting body to express their opinion and use their voting right freely and fearlessly. Professional training has enabled PMs in dealing with ratification and passing the laws, drafting regulations and rules.

g) Coordination

Despite achievement a number of the objectives of CP3 fully or partially, coordination and collaboration require strengthening. A number of coordination groups are gathered around data collection, such as the UN Data for Development Coordination Group which was initiated and chaired by UNFPA, conducted twice per year. Ministries such as the Ministries of Education and Public Health have well developed data systems and expertise to share.

5.1.4 Efficiency

For the PD focus on institutional strengthening of CSO, the flow of resources has the potential of producing significant results both for the census/survey capacity in the country and to serve planning purposes for gender, youth and RH programmes, among others. For example, the Humanitarian Assistance section is implementing a programme with ANDMA for development of district disaster plans using SDES information. The dramatic bulge in youth demographics is being confirmed through the SDES, hopefully leading to greater focus on youth empowerment and sexual and reproductive health.

Lessons learned exercises in the Bamiyan Participatory Dialog workshop served to put forth prioritized concerns as to where future efforts need to be strengthened. A number of problems in the Bamiyan SDES might have been avoided through stronger advance planning and communications.⁵⁵ These included:

- Unreasonable delays in payment for the enumerators and controllers (monitors)
- Payment channels and mechanisms of payment were unclear due to complexities and gaps in the national banking system
- Quality and duration of the training for the field personnel were not sufficient which resulted in returning many survey questionnaires for correction. If spot checking and quality control activities during the data collection had been augmented and more timely, extra expenses and efforts might have been avoided.
- Entitlements for DSA for surveyors, cartographers and controllers for attending the training sessions in Bamiyan did not cover the actual transportation and accommodation expenses especially for those traveling from districts with overnights in the city.

Workshop participants mentioned the following means to strengthen data collection strategies.

- Well prepared field operation plan before start of the survey
- Improve logistics and financial management of the survey- delivery of survey materials and equipment to the field ahead of time
- Identification of difficulties in data collection, and strategic anticipation for the recruitment, training, data processing, enumeration and other
- Use of local people especially in insecure areas
- Good coordination with local authorities ahead of data collection.

Approximately 65% of Japanese funds for the SDES in Bamiyan, Ghor and Daikundi was spent. The Japanese government has agreed to use the remaining 35% for conducting the SDES in two other provinces (Kapisa and Parwan). Since UNFPA has more than one donor in supporting the CSO to conduct the SDES, there should be close collaboration, coordination and communications between the CSO, the donors and UNFPA. UNFPA generally coordinates very effectively with donors but the chain of communications was not always carefully followed as per the donor's own institutional structures and requirements, possibly creating some misunderstanding. Typically, communications between programme and project officers move up the management system to the highest level so that high level staff are well informed about implementation and administrative details. There are various ways to look at efficiency, so UNFPA and donors should be in agreement on the best way forward and the rationale clear to everyone both in the donor country and in Afghanistan, for instance, UNFPA and CSO have their own logic behind selecting these four provinces, but the flow of the target areas must make sense to the stakeholders. Some of the weaknesses and lessons learned from the Bamiyan SDES pointed out during the Kabul workshop are presented in the following matrix.

Weaknesses
Time limitation for the implementation of the project (1 dot)
Weak trainers and unfamiliarity of the cartographers with the area (1 dot)
Lack of quality control mechanism and disorganized delivery of survey materials and supply(1 dot)
No specific salary(rate) for the surveyors at the beginning of the survey (1 dot)
Lesson Learned
Coordination between the donors, UNFPA, CSO and provincial offices (5 dots)
On time payment of field personnel (6 dots)
Develop comprehensive field operation plan considering the geographical status of the areas and the communities (4 dots)

⁵⁵ Compiled from interviews and outputs from the Bamiyan and Kabul CP3 evaluation

5.1.5 Sustainability

In order to move the SDES forward expeditiously, UNFPA should conduct more resource mobilization, seeking funds from sources such as South Korea, Sweden, and the private sector, including interested donors in Afghanistan. As mentioned by the government representatives, donors and other national and international bodies, the footprint of UNFPA is quite dominant in building capacity of CSO. However, to support the roll out of the SDES, more efforts are needed to implement CSO capacity building.

A National Statistical Capacity Development Plan was developed with the help of the World Bank, however, its successful implementation requires an accompanying motivational policy to keep trained staff and avoid losing them to other organizations. Support for CSO leadership to promote better collaboration and coordination of the donors and producing sustainable results needs to be highlighted. The CSO coordination and training department, has developed a training strategy with UNDP and needs consultancy services to support this plan especially in the provinces. Investments are being made in national staff, either while working or in the potential work force, in data processing and data analysis and should be continued to create a greater pool of national expertise to draw from. In this way the national ownership can be more effectively promoted by the CO.

The CP3 participatory dialog workshops in Bamiyan and Kabul emphasized continuation of building national capacities, mentoring and coaching of national staff by international consultants, involvement of communities in projects such as selecting cartographers, surveyors from local qualified people, explaining the benefit of this kind of surveys in simple words to the community, and increasing awareness on data use for development and emergency preparedness plans. The following matrix presents the PD's input regarding sustainability.

	Sustainability, what is needed to ensure local capacities in program implementation of long term viability of the PD CSO support programme
1	Increase ownership and participation of the community in projects (4 dots)
2	Increase motivation through job promotion and training in-house and abroad
3	Advocate for additional government fund for statistical activities
4	Advocate for participation and contribution of ministries and local government
5	Develop appropriate communication, human resources, data dissemination, data security policies and strategies
6	Improve international standards compliance

5.2 Gender Equality

Gender equality is a formidable challenge in Afghanistan where the Gender Inequality Index, which reflects gender inequality along three dimensions – reproductive health, empowerment, and the labor market – ranked Afghanistan for 2012, 147 out of 186 countries.⁵⁶ The average woman has a life span of 44 years, placing Afghan women's status second from the last in the world.

Existing cultural practices perpetuate gender inequalities that subordinate women to men and limits her reaching her full potential as an active political, economic and social actor of her own development and that of the family. Poor health practices mean that women have less access to health information, health care, services and resources to protect their health. Due to low literacy levels and access to education, women are further disadvantaged in their ability to make informed decisions about their political, economic and social well-being and that of their children.⁵⁷ Current gender norms work against women's empowerment.

⁵⁶ As rated by five indicators: maternal mortality and adolescent fertility for reproductive health, parliamentary representation and educational attainment for empowerment, and labor force participation for the labor market (UNDP Human Development Report 2013, pages 156-159.

⁵⁷ National Gender Strategy, 2012-2016.

The CPAP 3 defined the following outcome area and two outputs for Gender Equality:

Outcome 1: By 2013, an environment conducive to empowering women and eliminating gender-based violence is created in target provinces.

Output 1.1. Increased participation of women in decision-making that related to healthy families and livelihoods, at household and community levels.

Output 1.2. Enhanced capacity of target communities to identify opportunities for women's involvement in family and community life, and to prevent, respond to and monitor gender-based violence

5.2.1. Relevance

Alignment of UNFPA Support to ANDS and National Strategies

Because of historic and current disadvantages faced by women, special attention must be given to elevating women's position and status in Afghanistan. Commitments to gender equality and equity are embodied in the Constitution of 2003 and a number of strategic documents. Article 3 of the Constitution ensures that no law can be contrary to the beliefs and provisions of the sacred religion of Islam, and in that context guarantees equal rights for men and women.

Afghanistan laws, policies and strategies also provide the regulatory framework to support gender equality interventions. For example, the ANDS emphasizes the importance of building on the progress made in the last few years and seeks to increase its efforts to realize the vision of gender equality. Gender responsive development is seen as contributing to the reconstruction of the country, economic growth and poverty reduction. Under the ANDS, the Gender Equity Cross-cutting Strategy is the basis for addressing and reversing women's historical disadvantage by providing a roadmap for various sectors to bring about changes in women's position in society, their socio-economic condition and access to development opportunities. The Gender Unit's work with the Health Sector, the Policy Academy and the implementation of the National Action Plan for Women (NAPWA) is consistent with the National Priority Programme.

Country Programme Strategies Relevance and Responsiveness to National Needs

UNFPA's support to gender equality and GBV issues is highly consistent to national needs in Afghanistan. Violence against women is pervasive in Afghanistan. Rape, sexual assault and honour killings are the most serious human rights violations and the victims suffer the most severe physical, mental and social trauma. The most common type of honour killings are committed for sexual relations outside of marriage. An overwhelming majority of women experience at least one form of physical, sexual or psychological violence or forced marriage, and most experience multiple forms of violence. Violence against women (VAW) is more pervasive in provinces compared with the capital. Numerous studies prove that gender based violence has implications for every aspect of health policy and programming, from primary care to reproductive health programmes.

UNFPA's Support Consistent with Internationally Agreed Development Goals

The UNFPA's Gender Equality programme is also highly consistent with Afghanistan's policy environment which subscribes to key international conventions and treaties like the Beijing Platform for Action from the Fourth World Conference on Women (1985), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW, 1979) and the World Conference on Human Rights (1993). As a signatory to these conventions and treaties, the state of Afghanistan is committed to gender equality and equity and mainstreaming gender throughout the Government.

5.2.2 Effectiveness

Key Outputs of the Country Programme

Outcome 1: By 2013, an environment conducive to empowering women and eliminating gender-based violence is created in target provinces.

It should be noted that while the Country Programme Results Matrix defined one key outcome and two outputs with related indicators, data on progress toward the outcome results indicators is not systematically collected through, for example, surveys to test KAP. UNFPA routinely collects information received from the IPs on outputs, such as numbers of cases assisted and numbers of beneficiaries who participated in awareness campaigns. The outcome as described above is unrealistic for a programme cycle as it will take many years to create an environment conducive to eliminating violence in Afghanistan given the timeframe of the Country Programme is only 2010-2014. A better formulation would have been: Increased awareness in target communities of GBA and appropriate GBV services (e.g. through imams, hospitals, police, shuras, CHWs) given the timeframe of the Country Programme.

The following outputs have been noted which are seen as contributing to a more enabling environment able to respond more effectively to gender-based violence:

Health sector response to GBV. UNFPA established Family Protection Centres in Kabul and Jalalabad through the Development of Model and Standing Operating Procedures (SOP). UNFPA also trained health services providers and GBV Key Actors on GBV response and established GBV referral systems between GBV key actors in order to provide appropriate services to the GBV victims. Capacity-building of health services providers on GBV psychosocial counselling has also been given to over 294 persons.

Police Sector response to GBV. With the wide dissemination of the manual on “Police Taking Action on Violence Against Women”, UNFPA has also trained law enforcement bodies to strengthen their capacity to address GBV while maintaining ethical standards in the target provinces of Bamiyan, Daikundi, Kabul and Nangarhar.

GBV Data collection. UNFPA developed GBV data collection tools through technical and financial support of to MOPH.

GBV Sub cluster. UNFPA strengthened coordination and referrals mechanism among GBV key actors through the establishment of the GBV SCs (National and regional GBV SCs).

Advocacy. UNFPA developed tools on the elimination of early and child marriage and established a communication working group for the early and child marriage campaign. UNFPA also contributed in commemoration of international days.

Output 1.1. Increased participation of women in decision-making that related to healthy families and livelihoods, at household and community levels.

Increasing the participation of women in decision-making remains a priority given that representation of women in Shuras and Community Development Councils is low at 20 and 36% respectively against 70 and 68% for men. The Life skills training foreseen as part of this output was not undertaken as it is not part of UNFPA’s mandate.

UNFPA supported the MOHRA in the development of the healthy family and fortunate society book. Over 1500 of these books have been distributed. However, there are over 52,000 religious leaders in the country, thus demand for the book is great. Training took place for 200 religious leaders, Youth Groups, Health Shuras and Community Leaders and Community Health Workers on the GBV prevention and response in the target provinces on women’s rights, women’s health and domestic violence.

While increasing the participation of women in decision-making is a key UN priority, there is inadequate evidence on how UNFPA support has reached and affected decision-making at the household and community level. Nevertheless, the Family Health Houses at the community centre have inevitably raised the profile and status of mid-wives and the health houses in the community as was seen in our field visit.

Output 1.2. Enhanced capacity of target communities to identify opportunities for women’s involvement in family and community life, and to prevent, respond to and monitor gender-based violence

Health sector response to GBV

UNFPA started the initial efforts for integration of Health response to GBV in Afghanistan in 2011. For the first time, efforts to address the pervasive problem of GBV in Afghanistan were developed into a custom-made coordinated multi-agency GBV response system. In this connection the following achievements are highlighted:

1. The “Assessment of Services Provided to Victims of Gender Based Violence by State and Non-state Agencies” in Nangahar, Bamiyan and Kabul provinces was commissioned by UNFPA as part of expert support provided by UNFPA to the Ministry of Public Health and the Ministry of Women’s Affairs. The assessment confirmed that healthcare facilities in rural and urban areas were often the only option for GBV victims to seek assistance and protection outside of their family circle. However, healthcare facilities in all examined areas presented an impasse in the referral and reporting network that connected agencies working in the field of GBV response. Based on the assessment findings, UNFPA introduced a country specific health response to the GBV concept model and Standard Operation Procedures for full implementation in 2013. The National Priority Programme on Health (NPP5) introduced the GBV concept model under the essential package service component.

UNFPA established two Family Protection Centres , previously known as One Stop Assistance Centres, for victims of Gender–based Violence in two provinces of Afghanistan (Nangarhar and Kabul) in 2013, specifically Nangarhar Regional Hospital and Ibn-Sina Hospital in Kabul. The Centres seek to integrate professional assistance (psycho-social, medical and legal support and referral services into the health sector) and act as a pilot programmatic sub-component for a health sector’s response to address gender – based violence in Afghanistan.

To date, 112 women and girls have received GBV assistance at the Family Protection Centres in Kabul and Jalalabad. The majority of the abuse was physical violence 80% or above, psychological abuse, 10-15%, and others (denial of resources, forced marriage/early marriage). Only 4 cases of rape were reported in Nangarhar.

To date, 491 people were trained about GBV, the Family Protection Centres and the referral system; out of these 274 were female and 217 were male. There are 3 female and 3 male trainers in Nangarhar, while in Kabul there are 2 male trainers and 3 female trainers.

GBV survivors have limited access to services due to stringent cultural restrictions on women’s mobility and an acute shortage of professionals in the field of mental health and psychological counselling. UNFPA has worked towards building the capacity of Afghan health care providers for psychosocial counselling with specific focus on skills and techniques of dealing with GBV survivors. Since 2010, more than 600 health service providers have been trained on psychosocial counselling skills with the support of AADA and NRC Seconded, Mariette Abed Rabbi and Pennine Grater. Under 2013 AWP, the psychosocial counselling was introduced within the Family Protection Centres.

Police Sector Response to GBV

The UNFPA Programme on law-enforcement sector’s response to GBV is implemented since 2009 as part of institutional capacity building of Ministry of Interior and National Police Academy on engendering its educational curricula and training of police cadets, district commanders, Human Right and Family response Units’ personnel on addressing violence against women cases.

The course and comprehensive manual “Police Taking Action on Violence Against Women and Girls in Afghanistan” has been approved by the Ministry of Interior in May 2011 for integration into police training programmes.

As the next step, UNFPA provided expert support to Ministry of Interiors and National Police Academy on capacity building of Afghan National Police recruits in recognition and prevention of gender -based violence. Capacity-building has targeted the teaching staff of the National Police Academy and as well as police cadets, district commanders, chief of Human Right and Family response Units’ personnel and front-line police in Kabul, Nangarhar, Bamiyan and Daikundi provinces.

In 2011, UNFPA conducted a first Training-of-Trainers to 25 senior staff. Out of the 25 trainers, 6 senior staff are qualified as master trainers (3 women and 3 men trainers) of the National Police Academy and in 2012 for a

total of 48 trainings to different government staff (12 police, 7 judges and prosecutors, 7 line ministries staff, 8 NGO staff, 8 Youth organizations, and 6 religious leaders) have been conducted in four provinces of Afghanistan: Kabul, Nangarhar, Bamiyan and Daikundi. With the support of the Australian Government in 2013, UNFPA conducted 13 trainings for police and has extended the programme to other provinces in order to strengthen the capacity of frontline police officers (with a specific focus on female police officers) and other referral path actors, to appropriately address GBV/VAW where violence occurs.

The UNFPA project was mentioned as an achievement worth noting in the UN Secretary General Report for Afghanistan of 2010 and is of crucial importance in line with the transition process, withdrawal of international troops and strengthening the capacity of the national police force.

GBV Data collection.

Technical support to the MoPH on strengthening the capacity of health service providers on safe and ethical GBV cases data collection is another crucial component of health sector response to GBV. In cooperation with other partners (WHO, UNW) and upon the request of the MoPH, UNFPA rendered expert assistance on introducing GBV cases data collection mechanism and tools that are fully consistent with international ethical and safety standards and best practices. UNFPA supported MoPH on the development of the Intake Form and related SOP as well as capacity building of health directorates and data focal points in international standards in the area of GBV data collection and management. The training component was initiated in 2012 and so far 200 staff from different provinces have been trained.

The GBV Sub-Cluster

In 2010, the GBV Sub-Cluster (GBV SC) was established under the Protection Cluster of the Humanitarian Response system in Afghanistan to coordinate the actors who are engaged with activities to prevent and respond to GBV. UNFPA is the chair of the Sub-Cluster, with the Afghan Independent Human Rights Commission as Co-Chair.

The GBV SC consists of some 40 members, comprising local and international NGOs, Civil Society Organizations and UN agencies. To strengthen coordination and implementation across the country, GBV SCs/networks have also been initiated in the provinces Nangarhar, Balkh, Bamiyan, Kabul and Herat with the support of UN agencies and other partners. The main priority of the GBV SC is to establish functioning multi-sectoral referral and service mechanisms for GBV survivors, by strengthening collaborations between various actors.

The GBV SC mainly focuses on several areas of work. In 2011, the training of GBV capacity promoters was organized within the framework of a regional project funded by the European Commission. The capacity promoters further worked to organize, facilitate and support the introduction and/or rolling out of several core tools for good quality GBV programming and coordination. At the end of the training, the participants' knowledge about GBV, GBV Information Management Systems and GBV tools had increased notably. In addition, a Gender Marker orientation session for national and international organizations was conducted jointly by UNFPA and the GenCap Interagency Gender Advisor to Afghanistan in October 2012. In November 2012, the training on GBV in Emergency was delivered by IASC GBV AoR Asia Pacific Regional Advisor for functioning GBV SC in Eastern Region. Regional GBV Sub-clusters have been established in the Eastern region (2012), Western region (2013) and the Northern region (2013). Training on GBV and Child Protection in humanitarian settings for focal points of these structures was conducted in May 2013.

In the field of GBV data collection strong efforts have been put in place as well. Specifically the concept of GBV Information Management System and Data collection have been introduced to the GBV SC member organizations.

Linkages have been made with the Child Protection in Emergencies Sub-Cluster. The sub-clusters have collaborated on organizing the GBV-CP training for GBV SC and CPAN representatives.

The GBV SC has made linkages to the newly established Psychosocial Task Force under the CPiE cluster to strengthen the psychosocial support provided to GBV survivors within referral mechanism, and notably within One Stop Assistance Centres (OSAC).

Advocacy

UNFPA undertook a number of educational and advocacy campaigns such as the “16 Days of Activism Against VAW and the the problem of early marriages. UNFPA leads the Interagency Taskforce on early marriage comprising of UNICEF, UN Women, UNDP and UNAMA. UNFPA conducted a number of grassroots level campaigns using the cartoon story and animation about the possible risks of early marriage for very young girls and related health consequences - the materials are understandable for illiterate Afghans. The campaigns had the objective to promote an understanding of the problem and raise awareness that girls who are forced into early marriages are at much higher risk of suffering from sexual and domestic violence, multiple problems in their future development including isolation, health problems and lack of education.

Jointly with EUPOL, UNFPA has developed the similar behavior-change and educational materials that explain the role of police to combat VAW and girls. The dissemination to provinces and districts of materials were undertaken with the support of different actors and existing networks of civil society networks.

Critical Gaps in Gender Equality

Some of the most important gaps in GE reside with the UNFPA internally. UNFPA needs to walk the talk or talk the talk with regards to Gender Equality as a UNFPA office in Afghanistan. There are a number of areas requiring strengthening:

1. HR recruitment of women into professional positions. There are a paucity of women in senior management positions (0), as National Programme Officers (0) or in professional positions (5 out of 14). Positions held by women are mainly at the Assistant level (4 out of 17) (see Annex 5). In the Reproductive Health Programme, there are no women professionals despite the fact that women are a key target group for this programme. The newly appointed (international staff) head of the RH Unit is a woman and will take up her post in October as will the new Representative who is also a woman. In the area of Population and Development, there is also only one census specialist who is a woman, although data collection targeting women and their household is key as well as the collection of gender disaggregated data.

To correct this imbalance, UNFPA needs an Affirmative Action Policy that recognizes years of experience not only academic qualifications (i.e. as does UNICEF and UN Women who have a majority of women professionals on staff) and greater flexibility in its hiring practices. Academic qualifications alone cannot be the only criteria for hiring given disadvantages women have faced in the past to pursue educational opportunities. If UNFPA continues to insist on academic qualifications, systemic discrimination against women, in the hiring practices of the UNFPA office in Afghanistan, will continue.

2. Training on Gender. The last training on gender took place in 2010. There is a need to introduce staff to key concepts underlying gender equality (i.e. Equal treatment vs. equal outcomes; position vs. status; strategic vs. practical needs; gender vs. sex, gender equity vs. gender equality, etc.) different gender analytic frameworks and key strategies for gender mainstreaming and audit. To encourage participation of women in the courses, a subsidy should be provided to those women who may encounter barriers to participation if they are not accompanied by a chaperone.

3. Mainstreaming Gender into UNFPA's programme. Gender has not been mainstreamed into UNFPA's other programmes like Reproductive Health and Population and Development in any systematic way. Each programme needs a Gender Strategy that outlines the differential needs and priorities of women and men in reproductive health and population and development and clear strategies, indicators and targets to achieve gender equality.

4. Gender Roster. UNFPA should establish a gender roster in its field of expertise that can be drawn down by UNFPA, other UN agencies, Government and NGOs. This would help in creating a critical mass of Afghan and international experts in core areas of UNFPA's expertise.

5.2.3 Efficiency

Quantity and quality of results versus inputs

Gender based violence is considered a pervasive problem in Afghanistan. UNFPA has committed USD\$ 6 million or 15.5% of the total budget of USD \$ 38.8 million to GE and has been very successful in mobilizing another \$5.8 million for the next two years from Korea, Italy, Japan and Canada to fund various GBV initiatives. While budget allocations and disbursement levels were low in 2010 and 2011 due to lack of staffing and the absence of the Gender Coordinator for the Gender Unit, disbursements have picked up for 2012/13 and average around 90% for allocated funds, a very good rate of disbursement.

The combination of the core budget and mobilization of additional resources totaling \$11.8 million reflects the large demand for gender services and support. Much work is still needed on child marriage and ASRF, core niche areas for UNFPA support at a global level that are lacking in Afghanistan.

Appropriateness of available resources

Staffing, technology and equipment were considered by Implementing Partners (IPs) to be sufficient to support the achievement of programme outputs. The only area requiring further support is staffing which is considered insufficient to properly manage the programme. With current programming, there is a need for three more staff members: 1) an international consultant for the Gender Position; 2) a GBV Sub-cluster leader headed by a national, and, 3) a professional overseeing the policy aspects and GBV. If the programme expands during the CP4, more staff will be required to oversee gender mainstreaming within UNFPA and oversee new foci such as child marriage and ASRH.

Adequateness of Intervention Mechanisms

UNFPA's regulatory framework was seen as cumbersome by some of the IPs. On the one hand, some stakeholders have complained of micro-management by UNFPA. On the other hand, UNFPA has pointed out the importance of monitoring project activities or risk falling behind in the timely execution of activities. A balance is required so that IPs work at a reasonable pace without undue interference.

Focus on Core Activities able to Product Significant Results

As noted under the section of effectiveness, UNFPA has been an important player in raising awareness on Gender-based violence. The two Family Protection Centres established in Kabul and Jalalabad for GBV survivors are important centres offering women multi-service support for gender based violence and are producing significant results for women victim of violence. The Family Workshops for Training of Trainers (TOTs) and building of capacity of stakeholders in Gender Based Violence Response and Reproductive Health have produced important results for the country. Stakeholders receiving GBV training for the Police Academy offered the following testimonials.

<p>Female, 28, Head of Family Response Unit. I learned the following things in the Police Academy workshop:</p> <ul style="list-style-type: none"> - Observing human rights - Learned that women's rights are protected by the Laws of Afghanistan (the laws of the country can provide a bases to support women victims of violence) - The Law on Elimination of VAW - Learned about other provisions of Afghanistan Laws that provides a bases for dealing with cases of VAW - How the police should deal with Perpetrators of VAW cases as well as the perpetrators profile 	<p>Male, 42, Head of Family Response Unit. I learned the following things in the Police Academy workshop:</p> <ul style="list-style-type: none"> - Observing Human Rights - Observing the rights of women as equal members of the community with men - Prevention of violence against women and violation of their rights - Learned what specific articles of the laws of the country helps in dealing with cases of violence against women - How to follow up with case of VAW - How to approach the victims of VAW - Learned that cases of domestic violence, like any other cases of crime should be
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<ul style="list-style-type: none"> - Police should keep neutral when dealing with cases of VAW and should only act according to the law 	<ul style="list-style-type: none"> taken to the court. - Police should always act neutral when dealing with case of VAW
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5.2.4 Sustainability

Sustainability of Programmes and Continuation of Activities

Sustainability is a major challenge for the Government and implementing partners. For example, the Gender Unit of the Ministry of Public Health has an operating budget that covers only staff salaries. There are a total of four staff working in the gender unit of MOPH, two from MOPH and two of them are seconded from UNFPA and USAID overseeing \$4.1 million for the following donors: UNFPA, WHO and USAID. While office space is provided for this unit, it is inadequate and cramped. The Unit, like all Government entities, is not able to receive funds and works through implementing partners. For the future, the Gender Unit would like to increase its execution capacity by implementing 30% of the programme budget. But, in order to do this, institutional capacity for project execution and systems would need to take place.

Overall sustainability is quite weak given limited Government capacity to absorb such initiatives financially and execute these initiatives without Implementing Partners.

Institutionalized Policies and Strategies

Government stakeholders like the Gender Unit of the Ministry of Health and MOWA have key policy and programmatic documents in gender equality. For example, the Ministry of Public Health has a Gender strategy for its interventions in Health. The Ministry of Women Affairs also has a National Action Plan for the Ministry that highlights key pillars such as Security; Governance, Rule of Law and Human Rights; Economic and Social Development. These documents guide programme implementation, resource allocation and decision-making. Inclusion of the UNFPA supported activities budget into the Government budgets has not happened due to limited Government resources. At this stage, the only clear avenue of continuity would be if other donors were to pick up support where UNFPA support has ended. For example, the Ministry of Religious Affairs is receiving money from the Asia Foundation to publish 500 copies of the UNFPA financed book “Happy Family and Fortunate Society”. The Canadian Government has shown interest in supporting the FHH.

The Level, Nature and Quality of Coordination and Collaboration

The level, nature and quality of collaboration has been high with the Gender Based Violence Programme. For example, with UN Women there is joint support to conduct a KAP Survey of MOPH Health Clinics for GBV and the development of treatment protocol for GBV survivors also involving the WHO. With UNICEF, the work of the UNFPA Sub-Cluster on GBV was seen as gaining momentum with the arrival of the International Gender Consultant during the period April-June 2013. There was a joint Training Workshop between UNICEF and UNFPA on Child Protection involving key responders that was seen as a success by UNICEF. As UNFPA leads two task forces on GBV and Early Childhood Marriages (comprising of UNICEF, UN Women, UNDP and UNAMA), there is good collaboration with the other UN agencies and collaborators. With the European Union Police Commission in Afghanistan (EUPOL), UNFPA has jointly developed similar behaviour change and

educational materials that explain the role of the police to combat VAW and girls. UNFPA also works with the MoPH UN Women and WHO on the establishment of a GBV referral mechanism.

Collaboration with Implementing Partners like IMC and HAWCA has been considered good as per the IPs. There is also good collaboration between UNFPA and the IPs. The only suggestion from one of the government entities was less micro-management. In the future, there will be a need for UNFPA to do some lobbying with key donors to pick up funding where UNFPA cannot continue funding.

Engendering National Ownership, Leadership and National Capacity Development

While UNFPA has used Afghan Implementing Partners for UNFPA supported projects, Government ownership and leadership in executing project remains weak to non-existent. There is a need to build Government capacity to both monitor and evaluate UNFPA supported projects and to execute a minimum number of initiatives that can build Government capacity for project execution.

Country Office Interventions on Capacity-building and Contribution to Sustainability

Capacity-building has been an important component of UNFPA support to GBV. In each of the GBV components whether covering the Family Protection Centres, the Police Academy, Health Sector Response or the work of the GBV sub-cluster, capacity building has played a prominent role in raising awareness of GBV, in introducing key concepts, in better understanding of women`s rights and their protection, in clarifying the different types of GBV and the role of the state, MOPH and key state actors like the police, judges and prosecutors in GBV.

The following table summarizes capacity-building funded by the Gender programme. As can be noted in the table below, a total of 3509 persons were trained in various aspects of GBV. There was relative parity between women and men in terms of the number trained with the number of women 1838 exceeding the men for a total of 1671; about a 10% difference favouring women.

Table 5: Type of Training Funded by the Gender Programme	# Female	# Male	Total
1. Training of Health Service Providers and GBV actors on GBV Response	850	650	1500
2. Capacity-building of health service providers on GBV psycho-social counselling	207	87	294
3. Police Sector Training for law enforcement bodies	29	142	171
4. Religious leaders, youth groups, health shuras and community leaders and CHWs trained on GBV prevention and response	79	145	224
5. Health shuras, community leaders and religious leaders trained.	123	180	303
6. 28 trainings involving National Police Academy (NPA) staff, police, cadets, district commanders, Chief of Human Rights	260	244	504
7. Training of Family Protection Centre staff and Hospital staff	274	217	491
8. GBV Sub-Cluster training of GBV capacity promoters	31	24	55
9. GBV Response in Humanitarian Settings	17	9	26
Total	1870	1698	3568

Of the respondents who replied to the questionnaire, all rated the training they received (ToT of GBV Health Response to GBV) as high to very high. Key skills and tools learned included SOP, ethical guidelines for GBV data collection, strengthening coordination mechanisms and GBV terms and definitions. In terms of the impact the training had, one person noted: "I understand that now I am a GBV capacity promoter and responsible for transferring my skills to others and I did it: facilitated the training for GBV actors and health workers in Kabul and Nangarhar."

"After the establishment of the UNFPA programme in our region, the following changes have happened in my life:

- learned the importance of health
- learned from surveys: social and political issues

- decrease the mortality rate of children and mothers
 - create a strong family in order to have enough information and awareness of health issues...”
- Male stakeholder from Bamiyan 2013

Where UNFPA needs to focus its attention is on the evaluation of all the capacity-building workshops it has undertaken and the impact it has had on changing behaviours, attitudes and practices with regards to GBV and gender equality. A tracer study in this regard would be worthwhile.

Chapter 6 Strategic Positioning and Future Directions

6.1 Strategic Management

6.1.1 Human Resources Assessment

In 2007, the UNFPA Afghanistan Country Office organigram indicated that there were 25 office staff out of a total of 40 staff while the most recent organigram contains a total of 80 positions (see Annex 5). Given the growth of the CO, a human resources assessment is needed which would help the CO to appropriately position staff with the relevant contracts, such as fixed term or SSA, and updated job descriptions in addition to review of potential for professional growth and development within UNFPA to motivate and retain staff. The unfilled Deputy Representative position has imposed large burdens on other management positions and this position should be expeditiously filled.

This report has pointed out considerations for a human resources assessment:

- The new activities for development of district disaster preparedness and plans in addition to the MISP work and coordination functions will overstretch the HA staff and a new position may be required.
- The Youth Unit may require additional staff.
- UNFPA has positioned sufficient staff to effectively oversee the PD programme
- The Gender Unit requires three additional staff due to the demand for services
- UNFPA needs to demonstrate its dedication to the empowerment of women and adjust its hiring policies to allow more women to have the opportunity to work for UNFPA in Afghanistan and share their skills
- Job descriptions of staff should clarify responsibilities for attendance at coordination and joint planning meetings to give UNFPA more voice and visibility.
- A greater number of professional positions should be filled with Afghan staff to facilitate capacity development with government partners, IPs and communities in the national languages.
- Consultant and technical assistance contracts need to have benchmarks for capacity transfer including methods and plans for evaluation of effectiveness.

6.1.2 Results Based Planning and Monitoring and Evaluation

The discussion in each programmatic area notes issues with the contents of the CPAP results matrix and it is clear that more realistic planning is required as well as updating the matrix periodically so that results can be effectively monitored and evaluated. Data on indicators should be available or plans made to collect it routinely. For example, for GE there is one key outcome and two outputs with related indicators, however, data has never been collected in a systematic way by UNFPA or the Gender Programme in particular. The outcome as described is unrealistic as it will take many years to create an environment conducive to eliminating violence in Afghanistan given the timeframe of the Country Programme is only 2010-2014. On the other hand, humanitarian assistance does not have a results area in the CPAP or indicators relevant to all of its areas of work.

The Monitoring and Evaluation (M&E) officer for UNFPA Afghanistan commenced his duties in April of 2013 after the absence of an M&E officer over the period of several years. The CO monitoring functions have suffered considerably from the lack of an M&E officer. The CO lacks an M&E system and tools to support programme management and implementation. Decision-making for the achievement of results is missing and thus the CO has not fully institutionalized results-based management. This is evidenced by confusion among staff over basic concepts like outputs and outcomes as opposed to activities and objectives. Since the country programmes tend to be set out as a series of activities, data should be collected on indicators or targets as defined in the initial results matrix. While the Annual Workplans do highlight the key activities and results to be achieved, reporting is principally activity based. Thus, decision-making is not informed by the planned results but rather by the progress in the implementation of activities and disbursement levels.

While staff did receive RBM training in 2012, they were not satisfied with the course - another course is planned for November 2013. This course should review operating systems to ensure that they are results-based and train staff and counterparts in RBM so that project implementation, monitoring, and reporting is results-based. M&E tools that could support programme management include a data base for the collection and analysis of data and M&E frameworks at the project level that identify the corresponding indicators, target, baseline and methods for collecting data. For example, with the completion of the draft ANYP and the closing of three YIC, the CO needs to regroup around youth and efficiently proceed to achieve the outcomes and outputs as per the CPAP, effectively using staff, partnerships and M&E tools to document evidence.

The office is also in need of a distinct M&E operating budget so that it can fulfill its M&E function. An M&E plan developed with the government counterparts would ensure greater coordination and collaboration in the M&E support function. The MoPH in particular has requested joint monitoring missions with its M&E office that are effectively supported to promote collaboration with UNFPA.

6.2 Strategic Positioning and Future Directions

The context in Afghanistan for conducting development work is difficult at best. Among the challenges are the constant threats to security, whereby daily security reports are needed to prevent staff from coming to harm whether in Kabul or in other areas of the country. Other well documented issues concern levels of corruption and manipulation of contracts and development resources which have undermined trust among stakeholders. Further the corporate environment among assistance agencies has tended to be one of competition rather than collaboration. However, the UN Resident Coordinator's office is seeing changes that are cause for optimism through greater levels of cooperation and coordination. Facilitating factors have been the sufficient levels of funding and dedicated staff to promote accomplishments, such as UNFPA has demonstrated in CP3.

As one of the smaller UN agencies, UNFPA has taken steps in CP3 to position itself strategically to contribute to national development goals, with ICPD objectives in the forefront. As a major planning year for the UN and the government, 2014 brings opportunities to make a greater impact. As part of the planning process for the UNDAF, UNFPA needs to be present and accounted for to ensure that its mandate and strengths are well represented.

The GoIRA high level representatives are speaking with one voice and clarifying what should be evidenced from future UNFPA support, and these are upheld through the recommendations in this evaluation.

- ✓ Greater evidence of UN Delivering As One
- ✓ Funds channeled through MoFA (aiming for 50%) – greater use of UNFPA core funds
- ✓ Reduction of parallel efforts, assurances of capacity transfer through human resources development strategies
- ✓ Greater use of media, civil society, community based bottom up planning
- ✓ Greater investment in women's organizations and women's professional training
- ✓ Greater sharing of reporting and stronger communications.

To increase the sustainability and efficiency of health programs and to harmonize donor support, there is a strong tendency to move away from vertical to more horizontal approaches in support of integrated national health systems. In such horizontal systems, donors support a national health plan and strategy, use common monitoring and evaluation methodologies and recognize the leadership of the local governments to coordinate the implementation of programs. The GoIRA in collaboration with some of its major development partners has started such a process by preparing for a SWAP and has proposed a system through which major donors would pool their development contributions through the government. To ensure that reproductive rights and SRH are given adequate priority in policies and in planning and budget allocations, UNFPA should strengthen its participation in this process.

Although these efforts are not yet common practice in many countries, support to a sector-wide approach is completely in line with UNFPA's Reproductive Rights and Sexual and Reproductive Health Framework. *"A means to ensure the inclusion of SRH in health sector planning and make functioning health systems work for SRH is to strengthen UNFPA participation in programme-based approaches and SWAPs and promote attention to SRH within national health-sector*

*strategic planning and budgeting*⁵⁸. There is no doubt that the implementation of a SWAP in the health sector will pose a number of difficulties. Capacity within the MoPH will have to be augmented to run the management of the SWAP, proper monitoring and evaluation systems will have to be developed and control mechanisms on procurement and financial aspects of the program will have to be installed. UNFPA has ample experience in these fields and could make a valuable contribution in this respect, recognizing that at country level this may require strengthening of UNFPA human resources and adjusting the skill mix to the specific requirements of SWAP in the country.⁵⁹

6.2.1 Strategic Positioning and Future Directions for Reproductive Health

The following discussion indicates that UNFPA should continue its current RH activities, building upon successes and niches created, with some modifications, and that they are well placed in terms of UNFPA's organizational mandates and niches and CO capacities. During the CP3, the MoPH with support from UNFPA piloted the Community Midwife Education (CME) programme to train and employ Community Midwives (CMW). In addition, Family Health Houses plus Mobile Support Teams (FHH+MST) were developed to provide basic health and RH services to remote and underserved or unserved communities. UNFPA in Afghanistan has contributed toward the global Campaign to End Fistula through establishment of surgical capacity in Kabul. New UNFPA initiatives should be pursued such as cervical cancer screening, introduction of implants, and creating Midwifery Led Birthing Centers as well as producing an appropriate and viable RHCS strategy and action plan.

A key overarching issue for the CP4 is the lack of data regarding knowledge, attitudes and practices related to FP and reasons for unmet needs. This data is crucial for designing appropriate interventions such as BCC campaigns, more effective IEC and media campaigns. It is recommended that UNFPA conduct a detailed KAP survey regarding all Afghanistan women's RH issues in order to address them through a mass media BCC campaign (see Annex RH1).

In order to promote community acceptance of RH messages, the previously successful approaches to sensitization of religious leaders should be continued, and topics expanded to cover early marriage and the importance of birth spacing. UNFPA's approach needs to surpass mere awareness-raising and aim for greater impact by devising activities for religious leaders to share in BCC activities addressing their local communities, through dedicating some Friday prayer speeches to women's RH issues. Further impact could be realized by greater targeting of messages toward men, youth and adolescents.

CME – At the community services level, UNFPA's support to midwifery training, based upon years of lessons and good practices, continues to be relevant, effective and largely sustainable and has contributed to efforts among other assistance providers with the MoPH to increase RH and basic health coverage nation-wide. It has also likely contributed to improving maternal mortality rates. Combining the FHH model with the placement of CMW has been an effective means to cover remote and underserved areas and undertaking the pilot has been widely recognized as a significant UNFPA contribution.

At the policy level, the AMA and the MoPH with UNFPA support has sustainably increased the potential for a higher quality of nursing and midwifery services through the development of standards in the National Policy and Strategy for Nursing and Midwifery Services 2011-2015 as well as the creation of the National Midwifery Council of Afghanistan (NMCA). During CP4, UNFPA should continue technical assistance to carry these efforts forward to support the establishment and proper functioning of the NMCA according to the five year action plan. It should advocate with donors to fund the physical establishment of the Council as well as to finance its operation.

Of strategic importance at both services and policy levels, UNFPA in conjunction with AMA and in coordination with the MoPH, should support development of a Midwifery Education and Faculty Development Strategy and support its implementation. Institutional development of AMA and OAM will raise their capacity to enable them to partner with UNFPA to implement needed mentorship programs for midwives, especially CMWs serving in FHH,

⁵⁸ UNFPA (2008), Making Reproductive Rights and Sexual and Reproductive Health a reality for all, p.12.

⁵⁹ Population Situation Analysis of Afghanistan, UNFPA, 2012, page 55.

which will result in enhancing synergies among UNFPA-supported activities, as well as increasing UNFPA's visibility in enhancing midwifery.

FHH+MST. Emphasis in CP3 was on successful implementation of the model by applying lessons as the programme was built. As part of the CP4, the MoPH and UNFPA should focus on evaluating the FHH+MST model including cost-efficiency and cost effectiveness in comparison with the Mobile Health Teams (MHT) which are used by the BPHS to cover remote catchment areas. The MHTs are also supported by other agencies such as UNICEF to cover unserved or underserved communities outside of the BPHS catchment areas.

The evaluation will provide a basis for advocacy efforts to fund and replicate the FHH+MST model as part of the BPHS. The MHT is not sustainable even as part of the MoPH-financed BPHS and current MHT running costs would likely be more effectively utilized to finance the establishment of static health facilities such as the FHH. UNFPA needs to consider whether it should discontinue funding the MHTs in CP4 and whether they can be replaced with the FHH+MSTs in the BPHS covered areas. Based on the evaluation, the MoPH with support and collaboration among UNFPA and other donors and UN agencies should develop a strategy and an action plan for coverage of all remote under and un-served communities over the next five years, with FHH+MST replacing the MHTs in the BPHS.

OF. Obstetric Fistula continues to be a serious problem due to early marriage, early childbirth, weak birth spacing and low quality of RH services with potentially devastating social impacts for women with unrepaired fistulas. Based on UNFPA's global niche and success of the institutional strengthening in Kabul, UNFPA should replicate the OF wards and surgical facilities in at least two other provinces to increase coverage and access. Furthermore advanced training for repair of complicated cases should be introduced in at least one of these sites with accompanying English training or translation services.

RHCS. A sustainable national RHCS strategy and action plan is still lacking and of increasing importance given the shift to less external dependency in 2014. During CP4, the MoPH with UNFPA support should promote collaboration with the major donors, especially the EU and WB, to produce a viable national RHCS strategy. This strategy should work towards achieving efficiency through economies of scale and good quality of purchased commodities through advocacy that the EU and WB shift commodity procurement from NGO to joint MoPH/donor procurement. The strategy should work towards building capacity of the MoPH to procure commodities as well as to manage pipeline, cold chain and warehouses. UNFPA should also provide needed technical assistance to strengthen capacity and to build needed governance structures in MoPH as well as to support human resource and infrastructure development of MoPH to implement the RHCS strategy.

6.2.2 Strategic Positioning and Future Directions for ASRH and Youth Development

UNFPA has strategically positioned its support to the development of the ANYP as a government led initiative and UNFPA offers value and can be accredited with ANYP and Youth Health Line support outcomes. However, at this juncture with the ANYP vetted for approval, the UNFPA's role and visibility to support the extremely relevant focus on youth, may be limited unless it works on a viable strategy through a well-developed youth strategy and programme, including capacity development for government counterparts and more community outreach ASRH activities. UNFPA staff working on youth affairs offer a strong base of experience and strategic thinking, thus utilizing their skills will contribute to effectiveness, efficiency and sustainability. To realize the potential of the CO for youth support, staff require strong backing from management and adequate budgetary allocations. To further strengthen focus on youth, more data is needed to verify the status of youth nationally, thus the SDES and other surveys should capture data on ASRH and data on different categories of youth useful for planning purposes, such as employment aged youth and youth eligible to vote.

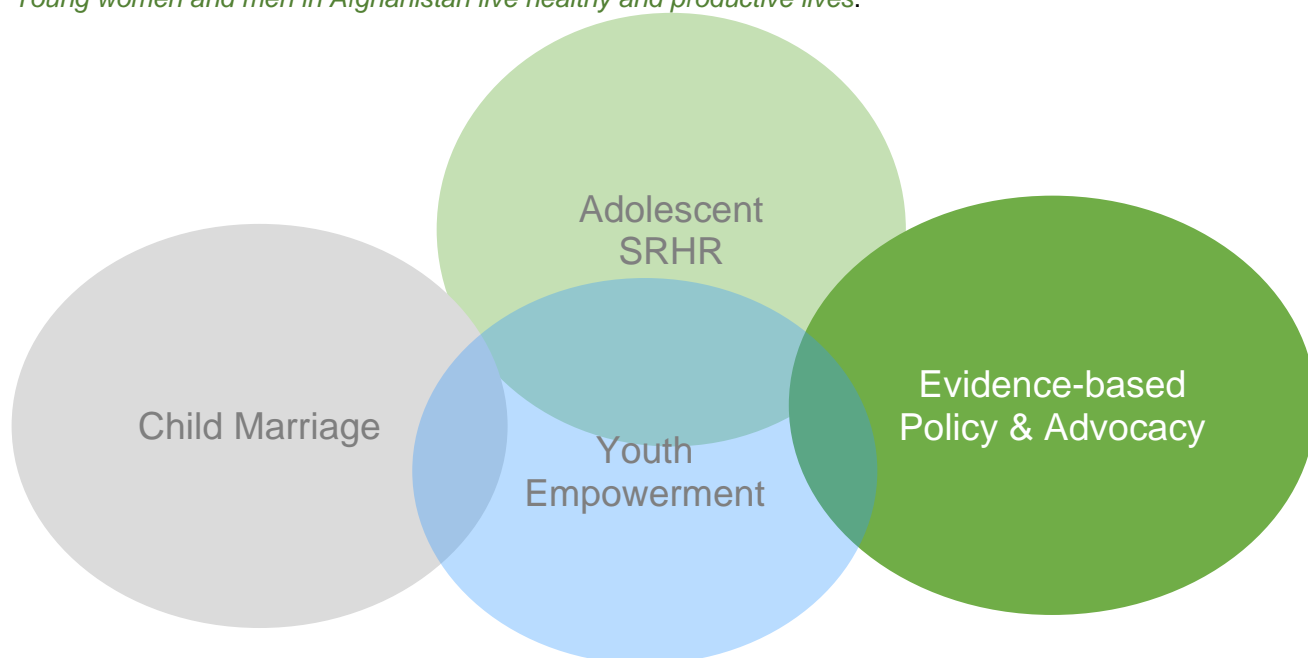
UNDP takes the lead among the UN agencies for youth as one with greater resources and a focus on livelihood development, a key priority of government, however, UNDP's own efforts have not been particularly successful due to weak government capacity and need for more funding. Based on the strong relationship developed among UNDP and UNFPA staff focusing on youth, plus high degrees of motivation, the agencies can complement each other's capacities while demonstrating the UN Delivering as One. Groundwork has been established for expanding collaboration with other stakeholders in youth assistance such as USAID and this should be extended to other donors and government stakeholders.

The youth section in collaboration with a senior advisor from the APRO have set out their tentative workplans for 2015-2018 which are very much in alignment with the UNFPA five pronged global youth strategy as depicted in the following diagram. This provides an example of good practice in developing realistic indicators.

UNFPA Afghanistan Adolescent and Youth Strategy 2014 to 2018

Development Objective:

Young women and men in Afghanistan live healthy and productive lives.



Global youth outcome: Increased priority on adolescents and youth, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health services.

6.2.3 Strategic Positioning and Future Directions for Humanitarian Assistance

The draft CCA (2013) for the development of the next UNDAF highlights the need to eliminate bureaucratic distinction between the activities of development and humanitarian agencies. Although there is a separate UNCT and UNHT, the UNCT agencies are mainly for development but include a small humanitarian component. In reality, Afghanistan represents a complex humanitarian situation where the 'disasters', both natural and man-made, are recurrent, frequent, and longstanding, their spatial configuration changes constantly, and the entire national government has had to be simultaneously re-built. The draft CCA goes on to pursue a focus on institutionalising a 'resilience agenda' to address the interconnectedness of these multiple vulnerabilities which is projected to be an underlying purpose of this next UNDAF. With these concepts in mind, humanitarian assistance is less likely to be in a separated system but rather more integrated into the development agenda.

UNFPA's approach to HA in the CP3 has been too piecemeal and reactionary instead of strategic. UNFPA should take advantage of the current planning period to expand the HA results areas and develop a strategic approach to disaster risk reduction (DRR) for which there are many funding opportunities. This would serve as to further strengthen the capacity of ANDMA and to highlight UNFPA taking more responsibility for supporting the entire MISIP for RH through training and advocacy rather than mainly the kits and packages. The Danish funding has presented an excellent opportunity to expand the district disaster preparedness planning based on

successful piloting in the currently programed 8 districts and this funding is likely to continue based on evaluation of the effort.

6.3.4 Strategic Positioning and Future Directions for Population and Development

UNFPA has provided significant added value to achieve ICPD goals and gained visibility through its well established partnership with CSO. UNFPA should continue to play a leadership role, supporting and strengthening leadership within the CSO for its own institutional development and further establishing its reputation as the national center for data collection, analysis and dissemination. UNFPA should promote CSO management capacity to organize donors and contributors under short and long term institutional development strategies, thus providing data users with the reliability and accessibility they are demanding. There is also a call for gathering expertise among the ministries for strengthening CSO and to expedite other provincial SDES. UNFPA and CSO need to advocate strongly in the ANDS and UNDAF development process for explicit inclusion of strategies to develop national statistical systems which have not been specifically set out in previous versions.

6.3.5 Strategic Positioning and Future Directions for Gender Equality

In the second quarter of 2012 from March 21-June 21st, the Ministry of Women Affairs recorded more than 1000 cases of violence, murder and suicide of women.⁶⁰ The work of UNFPA in GBV has been an important niche area of intervention for the organization where the need and demand for support services exceeds availability of services. It is generally recognized that women's rights and space (i.e. political, economic and social) in Afghanistan are slowly diminishing and the withdrawal of US troops in 2014 does not auger well for women's rights which are seen as diminishing. For example, the target of 33% of women in the civil service is only occupied by 8% of women. 30% of provincial council seats were reserved for women. Women now occupy only 20% of these seats. Girls' schools are closing at a rate of 3-6 a year. There are signs that violence against women is increasing by about 10-15%.⁶¹

As for the future, there is a need to consolidate the work with regards to the health sector response to GBV integrating GVB into the basic health packages of mid-wives and the GBV work with the Police Academy. There is also a need to continue the incipient work on ending child marriages and domestic violence. There is a need to consolidate past achievement by continuing the work of Gender Based Violence. In particular, there is a need to urgently recruit the Sub-Cluster Coordinator for GBV with the view of undertaking more training and capacity-building on humanitarian GBV prevention and expand GBV activities to IDP camps. The work with the Family Protection Centres also needs to be consolidated especially the referral mechanism and work scaled-up so that more women and their families can benefit from these Centres. Work with the Police Academy on GBV is important and should continue particularly in rural and remote areas. Support to the Ministry of Haj should be assessed for its effectiveness and impact.

In terms of new areas of support, the Gender Programme should be expanded to include early childhood marriage and sexual and reproductive health among adolescent youth. Accompanying these new initiatives, must be efforts to expand the mandate of the Gender Programme to include gender mainstreaming into other UNFPA programmes with clear Gender Action Plans for each programmatic area. Recruitment of women professionals must be a priority and an Affirmative Action Policy must be in place for progress to be made. Clear indicators will motivate Senior Management to meet greater gender parity targets in professional positions within UNFPA so that it can set an example for others to follow. A Gender Roster in the key programmatic areas of UNFPA support will also help build a critical mass of gender experts.

⁶⁰ The Outlook Afghanistan, October 1, 2012

⁶¹ Interview with HAWCA, September 17, 2013

Chapter 7 Conclusions and Recommendations

This chapter presents conclusions and offers recommendations to UNFPA and Government Counterparts, Implementing Partners, other UN agencies, donors and other stakeholders.

7.1 Conclusions

The evaluation conclusions are based on the findings detailed in the body of the report, regarding: Relevance, Effectiveness, Efficiency, Sustainability, Management and Strategic Positioning.

Relevance

UNFPA's support to Afghanistan has been planned in alignment to the ANDS, the MDG Strategy, the UNDAF and the ICPD and addresses some of the country's most pressing health and social development problems. The overall relevance is weakened by challenges posed by insecurity and in accessing remote communities which have required continuous adjustment of strategies and approaches. UNFPA has centered its efforts around objectives on the policy, institutional strengthening and community service levels, where its own capacity with IPs address requests by government partners, civil society, and complements other organizations' development inputs.

UNFPA's collaboration with the MoPH for Reproductive Health continues to be relevant as a contribution toward achieving MDGs 4 and 5 and strengthening RH services, through promotion of the RH Strategy which upholds the ICPD in alignment with the National Priority Program (NPP). UNFPA responded appropriately to cultural challenges through advocacy with Religious Leaders, male involvement, and expanding strategies to address women's health issues and choices for family planning. In some cases, UNFPA's assistance for RH has evolved past CPAP outcomes to include relevant actors (such as the AMA) working toward global goals for strengthening midwifery and addressing obstetric fistula.

Technical support for RH Commodity Security faces challenges due to lack of transfer of responsibility and absence of MoPH-owned RHCS strategy. The three major donors (USAID, World Bank and the European Union) are driving the purchase of contraceptives in the provinces and have not set out their exit strategies. However, the MoPH has formed a Coordinated Procurement and Distribution System (CPDS) Committee in 2011 to enable all donors to report on availability of commodities, hopefully leading to a nationally managed system.

The model Family Health Houses + Mobile Support Teams working in tandem with Community Midwifery Education (CME) are appropriate to serve remote geographic areas but require eventual adoption by the BPHS to promote sustainability. Relevance is challenged by inability of women in some communities to meet the CME requirements and thus some vulnerable communities in the UNFPA target provinces are not covered by these services.

Support for development of the Afghanistan National Youth Policy (ANYP) was extremely relevant, however, consolidated efforts of stakeholders with the DMoYA will be required to gain Cabinet approval and to operationalize the policy.

UNFPA's global mandate and experience in ASRH and youth development should have promoted stronger focus on youth-related activities as per the CPAP. The relevance of supporting youth was clear due to the implications of the youth bulge for national development but efforts suffered due to insufficient advocacy for youth in the ANDs and the UNDAF, varying definitions of adolescents and youth, and the CO not carrying out some of the CPAP planned activities. The activities undertaken on behalf of youth lacked a cohesive strategy and continuity. Further the youth health line and information centers were not pinned to an assessment which identified the most vulnerable youth and ways to reach them, or an analysis of the capacity of the Deputy Ministry for Youth Affairs which requires strengthening in programme management and outreach capabilities.

UNFPA's humanitarian assistance work is directly linked to outcomes in the ANDs and the UNDAF which promote preparedness measures and rapid response in view of the extreme vulnerability of Afghanistan to fragility, conflict, disaster risk, levels of poverty and vulnerability to climate change. UNFPA has contributed toward the Minimum Initial Service Packages through distribution of RH kits and personal dignity supplies to meet RH emergency requirements set by the *Sphere Minimum Standards*. Recent activities to support district preparedness plans with ANDMA using CSO data is extremely appropriate. Relevance has been somewhat adversely affected because the National Disaster Management Plan has not effectively integrated RH or GBV, a global UNFPA goal.

UNFPA's support to CSO's socio-demographic and economic survey (SDES) is well aligned with the country's need for population data; CSO capacity development needs strategic direction to meet data collection and user needs. Since the challenges to conducting a census are overwhelming, the SDES will provide province –wide denominators for monitoring the implementation and progress toward the ANDS, MDGs, as well as for the design of next UNDAF. Relevance has been weakened somewhat by debates over data collection coverage in the Bamiyan SDES, the use by some organizations of their own parallel systems and need to monitor and steer the utilization of data to promote greater satisfaction from users.

UNFPA's focus on gender equality is highly consistent with Afghanistan's policy environment and in view of national needs to uphold women's rights and to address violence against women. International treaties upheld include the Beijing Platform for Action (1985) and the CEDAW, 1979. National laws, policies and strategies include articles of the constitution, the ANDS and its Gender Equity Cross-cutting Strategy. An assessment helped to form the country specific health response to the GBV concept model. The police sector response project received acknowledgement in UN Secretary General Report for Afghanistan of 2010 as being of crucial importance in line with the transition process, withdrawal of international troops and strengthening the capacity of the national police force.

Effectiveness

UNFPA's technical support for MoPH capacity development has promoted effective response to national RH issues but more work is needed to increase the demand for RH services. Given the youth bulge, there is a gap in the institutional capacity development and services of the MoPH for adolescents and youth. The MoPH with UNFPA support branched into various options for RH as well as screening for cervical cancer. Given successes in sharing information and methods regarding RH to male health service providers, Religious Leaders and married couples, these activities should be intensified and effectively extended to youth. Funding from the Global Program for RH Commodity Security should also promote activities to increase demand.

UNFPA's activities are effectively elevating the standards and practice of midwifery, however, the NCMA needs support for establishing a physical presence and operations. Training of midwives for a number of years by the MoPH, supported by UNFPA among others, is widely believed to have contributed to the drop in maternal mortality documented in 2010.

The MoPH with UNFPA support has developed 82 functional Family Health Houses (FHH) and 9 Mobile Support Teams (MST) which hold potential for expansion. UNFPA also supports 4 Mobile Health Teams (MHT). Coverage is limited to only four of 34 provinces - the FHH + MSTs are operating in Faryab, Daikundi and Bamiyan ; in Herat they will be established over the next two years. In Badakhshan, only MHTs are operational. Community participation is key not only in selection of CMW but they also share in funding and building the FHH, with some financial support from UNFPA and managed by the *Shuras*.

Technical assistance for youth focused activities had mixed results. The youth health line is effective in answering thousands of calls and proxy data collection, but changes in KAP are less obvious and whether the line is accessible to the most vulnerable youth or can address the most prevalent problems. Peer counseling may continue to be successful if located elsewhere as the YIC were not efficient as a basis for drawing in youth to use the services and measuring progress toward the planned results.

The fragmentation of the youth support theme among the PD, Gender and RH results has not appeared to strengthen the outcomes. Rather, the youth focus has tended to become marginalized against the larger or more visible projects in RH, such as the FHH, and PD such as the CSO surveys. The youth focus appears as a group of separate activities rather than part of a strategic approach to addressing the problems of adolescents and youth. UNFPA will implement a cluster approach to aid the cross cutting of youth-related issues through the

other programmatic areas. Unifying themes may be to intensify focus on integrating child marriage and preventing early pregnancy across gender, RH PD and youth.

UNFPA supported humanitarian assistance has gained visibility in relation to use of the SDES data for disaster preparedness planning. The challenges will be to ensure that GBV and RH are included in the planning and training and are frequently monitored to promote sustainable capacity building for the government and communities. These planning exercises are still limited in coverage but will be expanded to 8 districts. The MISIP training activities were effectively designed and need to be replicated with follow-up evaluation.

The data on socio-demographic and economic status (SDES) of three provinces has been effectively collected. However, the advocacy to promote usage of the findings and data was not strategic. Stakeholders are demanding user friendly access to CSO data through various channels and in the form that is useful for their decision making and policy development. Although CSO has presented data in workshops and worked to raise awareness of data collection constraints, greater development of the CSO capacity to facilitate the user interface is important to engendering confidence in the national system.

Technical assistance for Gender Equality as per the CPAP has promoted more effective interventions; these include the police sector response, GBV data collection and the GBV Sub Cluster and advocacy efforts. More coverage and evidence of effectiveness would enhance the Gender Equality outcomes. The Family Protection Centres in Kabul and Jalalabad provide an array of services (i.e. psycho-social, medical and legal support) that go beyond awareness to actually support GBV victims. Effective police training resulted in expansion to other provinces. The GE programme has trained over 3,500 people playing a prominent role in raising awareness of GBV. Advocacy efforts utilized a wide range of approaches to awareness raising on GBV and early marriage. Evidence is inadequate as to how UNFPA support has reached and affected decision-making at the household level.

Gender Equality has not been mainstreamed into Reproductive Health and Population and Development in any systematic way. Although many CPAP activities transverse the programmatic areas, a Gender Strategy is lacking that outlines the differential needs and priorities of women and men in reproductive health and population and development and clear strategies, indicators and targets to achieve gender equality.

Efficiency

UNFPA's regulatory framework was seen as cumbersome by some of the IPs. On the one hand, some stakeholders have complained of micro-management by UNFPA. On the other hand, UNFPA has pointed out the importance of monitoring project activities or risk falling behind in the timely execution of activities. A balance is required so that IPs work at a reasonable pace without undue interference

Overall efficiency can be improved by advocacy and close communication with donors for reduction of earmarking and more flexibility as well as continuity to achieve Country Programme Action Plan (CPAP) results. UNFPA should avoid accepting funds from donors that do not efficiently lead to achievement of the planned results such as in Badakhshan where donors opted to support only the MHT and not the FHH. More support is needed to implement capacity development plans which will require close coordination and communications between the CSO, all of its donors and UNFPA. **Greater collaboration with other agencies** for all programmatic areas will close gaps and prevent duplication.

UNFPA and the MoPH need closer collaboration on training outcomes, and approaches to RH and FP methods that are new to Afghanistan. Some trained physicians in OF repair and some trained in Logistics Management Information Systems (LMIS) have not used their skills, thus training programmes need to be more carefully planned based on assessments and MOUs or agreements with the health institutions may be required to ensure that expensive training is not wasted.

Weaknesses in implementation of the Youth Information Centers and failure to promote the teacher training activities represented a serious loss in momentum during the CP3 to meet ASRH and youth development goals. Approximately 50% of the planned youth budget (dedicated to teacher training and curriculum development) was not used due to difficulties in gathering partner support. Actual spending on the youth-specific activities, approximately \$1.3 m comprises less than 3.5% of the CO budget. An evaluation is needed to assess what the issues were in operating the YIC to substantiate the investment and extract good practices and lessons.

For the PD focus on institutional strengthening of CSO, the flow of resources has the potential of producing significant results both for the census/survey capacity in the country and to serve planning purposes. Difficulties in disbursement to national implementers has affected quality such as data collection in the SDES. A number of problems in the Bamian SDES might have been avoided through stronger advance planning and communications; these are lessons being applied to ongoing and future surveys.

Disbursements on the Gender Equality programme have been very good although the percentage of CO funds and staff devoted are not sufficient to meet the need and demand for services. UNFPA resources for Gender Equality total USD\$ 6 million or 15.5% of the total budget of USD \$ 38.8 million which is not sufficient. Critical inputs that are producing significant results and need expansion and more monitoring include Family Protection Centres, TOTs for awareness raising and police training; more UNFPA staff are required to sufficiently manage the program.

Sustainability

Sustainability is a major challenge because GoIRA ownership and leadership in absorbing financial responsibility and executing projects is generally weak, despite GoIRA goals of administering 50% of programme budgets. Cohesive approaches are needed by all development partners to move capacity to the government and other Afghan stakeholders. Means and evidence of transfers of capacity are not always stipulated in MOUs and contracts – e.g. technical advisors should not be performing their tasks in isolation rather using coaching and mentoring with evaluated results. As demonstrated through RH and GE activities targeting of males and religious leaders promote sustainability. UNFPA successfully advocated for inclusion of ASRH into the Basic Package of Health Services (BPHS) and should work toward doing the same for the FHH

The FHH + MST + CME pilot project needs to be evaluated including cost effectiveness and replicated in other provinces to urgently address RH in the most vulnerable communities. The MoPH with support from UNFPA or other funding sources should replicate the most cost-effective complete model of FHH + MST. The number of proposed FHH to be established by the project has to be sufficiently large in order to conduct CME training efficiently.

The capacity of AMA and OAM requires strengthening to enable them to apply for and conduct complete programs with UNFPA support, such as the mentorship program for midwives. The NMCA needs to be established according to the produced five year action plan.

Institutional strengthening activities contributed to sustainable development for youth but more focus is needed on the youth-driven networks. UNFPA successfully advocated for inclusion of ASRH into the BPHS contributing toward an eventual Afghan-managed system. An assessment of health facilities was carried out to provide the basis for youth friendly services, including the youth health help line. UNFPA helped establish a Resource Centre with the Deputy Ministry of Youth Affairs. Dialog on incorporation of ASRH issues into the national curriculum has been resumed. Sustainability may be effectively pursued through the youth networks and community based organizations, but the support for their capacity development has so far been limited.

For CSO, greater investment and motivational support is needed to create a pool of well-trained data collectors and analysts. Stakeholders emphasize building national capacities, benchmarked mentoring and coaching of national staff by international consultants, involvement of communities in projects such as selecting cartographers, surveyors from local qualified people, explaining the benefit of this kind of surveys in simple words to the community, and increasing awareness on data use for development and emergency preparedness plans.

Promotion of sustainable outcomes for GE requires more collaboration among donors for continuity of support. Given the weak government capacity and staffing, continued support is needed to maintain and preserve the gains made to date, such as the extensive investment in capacity building and strategy development. An example of good practice is Asia Foundation support for the Ministry of Religious Affairs is to publish 500 copies of the UNFPA financed book “Happy Family and Fortunate Society”.

Management: Partnerships

UNFPA along with its IPs receives high marks for technical assistance and cooperation with other organizations, however, staffing shortages or unfilled positions have weakened UNFPA's presence in planning forums and follow-up and consequently UNFPA's influence in promoting the goals of the ICPD. The

partnerships through the IPs have resulted in good working relationships with provincial stakeholders. UNFPA participates in a number of coordination mechanisms but greater efforts are needed to work closely with government counterparts, other UN organizations, and donors to address development issues with one voice

More strategic and realistic results based planning with buy-in from all programme staff and partners is needed to anchor the programme. The CO monitoring functions have suffered from the lack of an M&E officer for most of the CP3 and the CO has not fully institutionalized results-based management. Data on indicators has not been collected systematically. A review of operating systems is important to ensure that they are results rather than activity based as well as development of a performance monitoring system. A jointly coordinated M&E plan with government and IPs that designates adequate time and resources to carry out joint M&E functions is vital.

A joint strategy for youth activities -evaluated as successful- is needed to support effective programming and is likely to produce significant funding results. There is evidence that reaching out to coordinate with other stakeholders investing in youth has paid off, some funding was received from USAID for joint activities. The level of cooperation and coordination among agencies assisting with the focus on youth require strengthening. Cooperation has been mainly piecemeal and fragmented and cooperative and collaborative relationships should be elaborated in a programmatic strategy.

UNFPA has provided sufficient staff and resources for the PD programme, the major challenge now is for CSO, UNFPA and other stakeholders to develop a coordinated vision on how to expand the surveys to other provinces and to use the outcome/data for future planning. As the takeover by the Afghanistan government of security concerns is looming, current efforts in capacity development of Afghan people and promoting local ownership need to be augmented.

The level, nature and quality of collaboration has been high in the Gender Based Violence Programme. Examples of good practice include joint support with UN Women to conduct a KAP Survey of MoPH Health Clinics for GBV and the development of treatment protocol for GBV survivors also involving WHO, and with UNICEF/UNFPA Training Workshop on Child Protection involving key responders and with UNICEF, the work of the UNFPA Sub-Cluster on GBV was seen as gaining momentum. With the European Union Police Commission (EUPOL), UNFPA developed behaviour change materials. UNFPA's leadership of two task forces on GBV and Early Childhood Marriages (comprising of UNICEF, UN Women, UNDP and UNAMA) has resulted in effective collaboration. Collaboration among UNFPA and IPs has also been strong.

Strategic Positioning

UNFPA has positioned CP3 more strategically than CP2 and needs to ensure that its mandate and strengths are well represented on the UNCT and throughout the UNDAF planning process. The GoIRA partners want **greater evidence of UN Delivering As One**, more resources channeled through MoFA, greater use of media, civil society, and community based bottom up planning, stronger investment in women's organizations and women's professional training, and greater sharing of reporting and stronger communications.

While the RH, PD and GE strategies are still largely viable, youth and humanitarian assistance results require greater focus and ensuring that transversal aspects are results-driven. Successes from the FHH pilot, youth health line, MISP training, and gender awareness raising, among others, should be replicated by UNFPA or other agencies as per their capacity to extend coverage.

The next UNDAF is likely to feature humanitarian assistance as part of the development strategy, highlighting the planning aspects. The new activities for development of district disaster preparedness and plans in addition to the MISP work and coordination functions, may overstretch the HA staff. Humanitarian assistance does not have a results area in the CPAP or indicators relevant to all of its areas of work.

The PD collaboration with the CSO has strongly engendered national ownership and use of the expertise within the CSO, however, a cohesive joint strategy for strengthening leadership and capacity development is needed. Stronger ministry and donor coordination and collaboration is needed to share insights for development of statistical systems and promotion of a faster high quality progress in completing more provincial SDES.

The work of UNFPA in GBV has been an important niche where the need and demand for support services exceeds availability and thus UNFPA should expand its role to support national efforts.

Women's influence and space (i.e. political, economic and social) are slowly diminishing and the withdrawal of military and development assistance is likely to further negatively impact women's rights. UNFPA needs to continue to support the health sector response to GBV, Family Protection Centers, work with the Police Academy, among others. Support to the Ministry of Haj should be assessed for its effectiveness and impact. In terms of new areas of support, the Gender Programme should be expanded to include early childhood marriage and sexual and reproductive health among adolescent youth.

Accompanying these new initiatives, must be efforts to expand the mandate of the Gender Programme to include gender mainstreaming into other UNFPA programmes with clear Gender Action Plans for each programmatic area. Recruitment of women professionals must be a priority and an Affirmative Action Policy must be in place for progress to be made. Clear indicators will motivate Senior Management to meet greater gender parity targets in professional positions within UNFPA so that it can set an example for others to follow. A Gender Roster in the key programmatic areas of UNFPA support will also help build a critical mass of gender experts.

7.2 Recommendations

The following are 15 prioritized recommendations directed to UNFPA to be carried out in cooperation, coordination, collaboration and jointly with GoIRA partners, implementing partners, donors and communities. These recommendations will be converted to a management response, and the timeliness of the response monitored by the UNFPA Country Office, the APRO and the Headquarters. Please see Annex 4 for additional details and suggestions for programme improvement which may contribute to CP4 planning discussions. These do not require a management response.

Relevance

1. Conduct assessments and surveys that will support effective targeting of resources, such as knowledge, attitude and practice (KAP) surveys to assess community understanding and practices regarding maternal mortality, obstetric fistula, early marriage, the SRH risks, ASRH, infertility, user interface and application of CSO data. Ensure surveys are well developed based on reviews of findings from relevant studies and surveys such as the MICS, the Afghanistan Mortality Study, and the SDES to capture demographic and other data and to identify gaps.
2. Strengthen emphasis on joint strategic planning processes and creating strategies and action plans for Reproductive Health Commodity Security (RHCS), Midwifery Education and Faculty Development, inclusion of the FHH+MST in the BPHS strategy, ASRH and youth development, inclusion of RH and GBV in the National Disaster Management Plan and district disaster preparedness plans.
3. Strengthen support for the placement and services of CMWs in FHH through targeting potential CME candidates with literacy training, monitoring the quality of support by the community for the CHW and assessing FHH CMW caseloads, hiring assistants where needed.

Effectiveness

4. Design behavior change communications (BCC) using multi-media on sexual and reproductive health including family planning in the context of Islam, birth spacing, breastfeeding, modern contraceptive methods, early marriage, pregnancy and postnatal health issues, need for skilled birth attendants, among others, engaging sensitized Religious Leaders in rural communities and urban areas, and especially targeting youth populations.
5. Expand effective capacity development and programmatic interventions, following review and evaluation, using UNFPA and/or other sources of funds, such as male involvement, training for religious leaders, annual refresher training for CMWs, technical training for IPs, the AMA mentorship programme for CMWs, extension of the health/help line to the provinces, district preparedness planning support to more districts, expediting SDES coverage through resources mobilization and expansion of CSO census expertise combined with new technology, GBV work with Family Protection Centres and the Police Academy, and support to the Ministry of the Haj.

6. Increase coverage and improve quality of the services to address Obstetric Fistula by training more dedicated physicians in basic and advanced fistulae repair, supplying modern equipment, such as the laparoscope and cystoscope as well as training on their use, replication of the OF wards and surgical facilities to increase coverage in the provinces.
7. Expand the UNFPA Gender Unit mandate to support gender mainstreaming into other programmatic areas and Human Resources; establish targets for recruitment of women professionals and a Gender Roster.

Efficiency

8. Ensure user friendliness for funds - streamline procedures for disbursements and work toward more accurate estimations for budgets to support quality work to reach programme objectives such as for enumerators/cartographers for CSO surveys.
9. Negotiate with donors to provide funding that ensures continuity and cohesiveness within provincial strategies to reach CP results. Maintain a well-established communications system with donors basing consultations on bottom up communication at the program officers and technical staff levels first to inform the higher level of management in regard to progress and monitoring.

Sustainability

10. Work with the DMoYA, CSO, AMA, OAM, NMCA and the MoPH to support their capacity assessment and development of their capacity building strategies.
11. Evaluate the pilot FHH + MST + CME pilot project including a costed model and advocate among the MoPH and donors for increasing coverage and replication to other provinces.

Management

12. Foster internal and external coordination mechanisms by regular and active presence at planning and coordination meetings, recruitment of new GBVSC Coordinator, strengthening the formal forum for generating population data led by CSO, and raising awareness of UNFPA's Gender Equality Programme among UN agencies.
13. Conduct an internal human resources assessment to prepare for CP4 and expansion of activities.
14. Develop an M&E Action Plan with Government that includes an M&E operating budget to cover M&E database, surveys, and joint field missions; Develop and align M&E systems so they are results based for coherence in the entire programme cycle. Define for CP4 realistic results, targets and indicators.

Strategic Positioning

15. Strengthen transversal aspects by creating a separate and higher profile unit for Adolescents and Youth pursuing stronger interventions for youth in less served focus areas, such as prevention of child and forced marriages and adolescent pregnancies, youth drug users and other marginalized youth, integrate ASRH in education and the FHH; and ensuring that transversal aspects are results driven.

Annex 1 – Persons Consulted

The following includes persons who participated in the evaluation consultations, including Key Informants, Focus Group Discussions, and persons who attended the two CP3 Lessons Learned workshops.

Key Informant Interviews

Government of the Islamic Republic of Afghanistan

1. Daiulhaq Abeed, Deputy Minister, Ministry of Hajj and Religious Affairs
2. Najla Areeb, Gender Advisor, Ministry of Public Health (MOPH)
3. Naziha Ahmadi, MoPH/UNFPA, FP Service Officer
4. Said Habib Arwal, Community Based Health Care (CBHC), MOPH
5. Sadia Fayeeg Ayubi, Director of Reproductive Health, MOPH
6. Hukum Khan Habibi, Deputy Minister for Technical Affairs, Ministry of Economy
7. Marghalya Khara, Director of Social and Economic Coordination, Ministry of Women Affairs
8. Hamrah Khan, Director of the Gender Unit, MOPH
9. Khudai Naza Nassart, Secretary General, House of People (Parliament)
10. Ahmad Jan Naeem, Deputy Minister of Technical Affairs, Ministry of Public Health
11. Nasreen Oryakhil, Trainer Specialist of Ob-GyN, President of Ob-Gyn Society, Malalai Hospital
12. Sayed Qazi, Director of International Relations, Afghan National Disaster Management Authority (ANDMA)
13. Ismail Ramini, Director General of Policy and Monitoring of ANDS, Ministry of the Economy
14. Hekmat Shahi “Rasooli”, Chief of Staff Office, Director of Gender Human Rights and Child Rights Department, Ministry of the Interior
15. Sayed Mustafa Saiedi, Director of Programmes and Youth Policy Development, Deputy Ministry of Youth
16. Ahmad Shah Salehi, Director Health Economics and Finance, Ministry of Public Health
17. Aslam Sayas, Director of Planning and Policy, ANDMA
18. Mr. Shoogofan, Director of UN Affairs and International Conferences, Ministry of Foreign Affairs

UNFPA

19. Nigina Abaszadeh, Gender Specialist, New York
20. Dinesh Agarwal, RH Advisor, Reproductive Health
21. Gihani Amin, Programme Officer, PDS
22. Abdul Basit, Programme Officer, Gender
23. Line Begby, Former Sub-Cluster Coordinator of GBV
24. Malin Bogren, Technical Midwife Advisor, RH
25. Richard Columbia, Regional Advisor, Asia and Pacific Regional Office (APRO)
26. Abdul Malik Faize, Programme Officer, RH
27. Mahie Faici, Programme Officer, Reproductive Health
28. Javed Hafizi, Finance Associate
29. Baryalai Helali, National Programme Officer, PDS and ASRH
30. Tahir Ghaznavi, Programme Officer, Reproductive Health
31. Mark Hutchinson, Head of Operations
32. Tahima Imali, HR Associate, Operations
33. Steffi Jochim, Youth Consultant, PDS/ASRH
34. Bashir Najeeb, Programme Officer, PD
35. Mohammad Younas Payab, Assistant Rep, PDS
36. Abdul Qadei Raza, NPO Humanitarian, Humanitarian
37. Javed Hafizi, Finance Associate, Operations
38. Mirwais Momani, Programme Assistant to Rep, Operations
39. Ahmadullah Molakhail, Program Coordinator for Sub-national Program, RH
40. Ruben Litan, Advocacy and Communication Specialist, Communication Unit
41. Jone Navakamocea, M and E Advisor

42. Josephine Sauvarin, Technical Advisor on HIV/ASRH, Asia and Pacific Regional Office (APRO)
43. Mercedita Tia, Census Tech Specialist, PDS
44. Ali Sabr Varzгани, Programme Finance Associate, RH
45. Laurent Zessler, Representative

Implementing Partners, Donors, UN Agencies and Others

46. Niamatullah Akbari, Chief Executive Officer, Afghan Family Guidance Association (AFGA)
47. Naheed Aman, Programme Officer, MOVE, Kabul
48. Abdul Qadir Baqakhail, Project Coordinator, MERLIN, Badakhshan
49. Mohammad Najeeb Baleegh, Senior Program Manager, AADA (Agency for Assistance and Development of Afghanistan)
50. Mini Bhaskar, Child Protection Specialist, UNICEF, Kabul
51. Jan G. Brouwer, Child Protection Specialist, Children and Armed Conflict, UNICEF, Kabul
52. Mohammad Raza Dadbig, Program Manager, MOVE
53. Farhad Farahmand, Senior Programme Manager, AADA
54. Johan Eidman, Coordination Officer, UN Resident Coordinator's Office
55. Fernando Gallardo, FSCO-CHR, UNAMA, Bamiyan
56. Adugna Tafa Gemechu, Finance Director, MERLIN, Kabul
57. Anne Louise Grinsted, Counselor, Royal Danish Embassy, DANIDA
58. SM Moazzem Hossain, UNICEF, Chief of Health & Nutrition Section
59. Feriba Hosham, HIV Project Manager, AFGA
60. Pamela Fatima Hussein, Deputy Country Representative, UN Women
61. Chihiro Imai, Programme Officer, Embassy of Japan
62. David Joy, Deputy, UN Resident Coordinator's Office
63. Abdul Maluk Khalili, General Director, MOVE, Kabul
64. Mursal Musawi, Executive Director, AMA
65. Etsuko Matsunaga, M&E Officer, UNICEF, Kabul
66. Mirzaman Malakzai, Project Manager, Disaster Management Response Project, YHDO,
67. M. Mulchlesurrehman, Consultant Analyst, YHDO
68. Adela Mubasher, WHO, MCH / National Professional Officer
69. Louisa Lippi, Social Policy, UNICEF, Kabul
70. L. Lutfullah, Project Manager, (Agency for Assistance and Development of Afghanistan) ACTD
71. Mohammed Rafi, National Youth Council, former YAP member
72. Abdul Latif Rashed, Programme Director, MOVE, Kabul
73. Abdul Rasheed, Executive Director, YHDO
74. Shafiq ur Rehman, Country Health Director, MERLIN, Kabul
75. Rizwanullah, GBV Coordinator, IMC
76. Najibullah Safi, National Professional Officer, WHO, Kabul
77. Abdurahman Shabab, Director General. ACTD
78. Farhat Sahek, Program Manager for Community Midwifery Education, AADA
79. Abdul Hadi Hazrat Shah, Results and Statistics Advisor, DFID
80. Redwanullah Subhami, Provincial Director, MOVE, Bamiyan

Focus Group Discussions

1. Ministry of Public Health Family Protection Centre: Dr. Durkhani Akbarzai, Psycho-social counselor, IMC; Dr. MehrAngaiz Areeb Baraz, OSAC Manager. Dr. Hazad Rahman, Project Manager. Nabill, Data Collection Officer.
2. UN Women: Pamela Fatima Hussein, Deputy Country Representative; Fazal Rahim Monib, M& E Officer, EVAW Pillar; Hangama Anwari, Programme Manager, EVAW Pillar.
3. Humanitarian Assistance for the Women and Children of Afghanistan (HAWCA): Ubaid Ahmad; Homa Habib; Wahid Ahmadi.

4. Ministry of Public Health: Admad Jan Naeem, Deputy Minister Technical Affairs; Dr. Said Habib Arwal, CBHC National Coordinator; Mr. Alawi, Head of Child and Adolescent Health Department; Ibne Amin, Director of Monitoring and Evaluation; Dr. Sadia Faraq Ayubi, Director of Reproductive Health.
5. Sarmagol, Bamiyan Family Health House (FHH): Mid-wife, 7 women clients of Family Health Centre, Father of Mid-wife.
6. GBV Training of Response to GBV Group of about 25 persons (13 women and 12 men) including medical professionals, CARE International, ACF, Hegar International, MOWA and Cooperation.
7. ToT for Police Staff on Prevention and Responses to cases of VAW in Afghanistan, 14 men and 4 women police staff
8. AFGA Youth Peer to Peer Counseling: 2 Trainers and 9 peer counselors
9. AFGA Youth Health Line: 4 Counselors
10. UNFPA: Debrief of Evaluation, 14 Staff

List of Participants for the Participatory Dialogue for CP3 Programme and Future Directions
Venue: UNAMA Conference Room, Tuesday 17th September, 2013
8.00am – 2.30pm

	Name	Organization	Title and Designation	Address	Telephone	email
Population and Development						
1	Mr Samai Nabi	Central Statistics Office	Director of Field Operations & Sampling Survey	CSO		
2	Mr Esmatullah Ramzi	Central Statistics Office	Adviser, CSO	CSO		
3	Mr. Sayedi	DMYOA	Head of Policy & Planning	DMYOA		
4	Mr Mohamad Younus Payab	UNFPA	Assistant Representative	UNFPA		payab@unfpa.org
5	Ms Tia Meredita	UNFPA	Census Technical Advisor	UNFPA		tia@unfpa.org
6	Dr Bashir Najeeb	UNFPA	Programme Officer	UNFPA		najeeb@unfpa.org
7	Vincent Volviar	UNFPA	Data Processing Expert	UNFPA	0704 514 267	
Gender						
8	Ms. Malghalara Khara	MOWA	Head of Health Projects	MOWA	0700288562	
9	Colonel Hekmat Shahi Rasooli	MOI	Director of Gender and Human Rights	MOI	0799146001	hekmat.shahi@moi.gov.af
10	Dr Hamran Khan	MoPH	Director of Gender and Human Rights	MoPH	0799144415	
11	Ms Mehrangzeeb	FPC	Manager, FPC	FPC	0707204622	
12	Ms Selay Ghafar	HAWCA	Director	HAWCA	0797075976	
13	Dr. Rizwanullah	IMC	Project Coordinator	IMC	0708194314	
14	Ms Homa Safi	AWN	Manager	AWN		
15	Dr Abdul Basit	UNFPA	Programme Officer, Gender Unit	UNFPA		basit@unfpa.org
16	Dr. Najla Areeb	UNFPA	Technical Associate, Gender Unit	UNFPA	0799370370	areeb-najla@gmail.com
Youth						
17	Mr Sayed Ikram Afzali	Youth in Action Association	Director	Youth in Action Association		
18	Mr Zakia Suliman	AYCDO	Director	AYCDO		
19	Dr.Naimatullah Akbari	AFGA	Director	AFGA, Shadab Zafar Blocks, Aman Eye Hospital	0799023627	nakbari@afga.org.af
20	Ms Steffi Jochim	UNFPA	Youth & Development Specialist	UNFPA	0707198997	jochim@unfpa.org
Evaluation Team						
	Ms Sheila Read	UNFPA	International Consultant/Evaluator	UNFPA		sheilareed@earthlink.net
	Ms Francoise Coupal	UNFPA	International Consultant/Evaluator	UNFPA	+93704514280	fcoupal@mosaic-net-intl.ca
	Ms Mahinaz El-Helw	UNFPA	International Consultant/Evaluator	UNFPA	+93704514257	elhelwm@gmail.com
	Dr Palwasha Anwari	UNFPA	National Consultant/Evaluator	UNFPA	+93704514281	anwari@unfpa.org
	Jone Navakamocea	UNFPA	M&E Specialist	UNFPA	+93707198996	navakamocea@unfpa.org
UNFPA Management						
	Dr Laurent Zessler	UNFPA	Representative	UNFPA		zessler@unfpa.org

List of Participants for the Participatory Dialogue for CP3 Programme and Future Directions
Venue: Silk Road Hotel, Bamiyan - Saturday, 14th September, 2013
8.00am – 2.30pm

Name	Title	Organization
1. Nadira	<i>RH Officer</i>	AKHS_A
2. Rehana	RH Officer	Move
3. Sediqa	CBHC Officer	Move
4. Sediqa	Midwife	Move
5. Hussaindad Ahmad	Data entry	ACSFO
6. Abdul Hamid Surosh	Data Controller	former PSO clerk/jobless now
7. Omedzaman Maday	Surveyor	former PSO clerk/jobless now
8. Abdul Kazim	Surveyor	PSO
9. M. Mohsen Zafari	Head of PSO Bamiyan	PSO
10. Mohammad Sadat		
11. Javed Rahmani	UNFPA Driver	UNFPA
12. M. Amin Paknyar	Data Controller	former PSO clerk/jobless now
13. Dr. Redwanullah Subhani	PMC Project Manager	Move
14. Fariba hassani	Training and M&E Officer Organization Development Officer	IMC
15. Suraia Hassany	Bamiyan Women Network Manager	Shuhada organization
16. Hamida Shujaee	Manager	Peace, Democracy and Equality Organization
17. Harifa Rezaee	CHW of Aangran FHH	Move
18. Ismayel Iqbali	CHW of Aangran FHH	Move
19. Rajab Ali Naveed	CHW of Sarbage Kalo FHH	Move
20. Amena	CHW of Sarbage Kalo FHH	Move
21. Ali Yad	Surveyor	UNFPA
22. Dr Khalid Rahim	Admin officer	AADA

Annex 2 – Documents Consulted

Government of the Islamic Republic of Afghanistan

1. *Afghanistan National Youth Policy*, Draft for Public Consultation, June 2013.
2. *Afghanistan Statistical Yearbook 2011-12*, Central Statistics Office
3. *National Child and Adolescent Health Strategy, 2009-2013*
4. *National Gender Strategy 2012-2016*, Ministry of Public Health, Gender Department, February 2012.
5. *Afghanistan National Development Strategy (ANDS), 2008-2013*.
6. *National Reproductive Health Strategy, 2012-2016*
7. *Bamiyan Socio-Demographic and Economic Survey*, Final Report, March 2011-2012, Central Statistics Office, 2013.
8. *Health for All Afghans*, National Priority Programme, Ministry of Public Health. June 2012.
9. Millennium Development Goals Report, 2010

UNFPA

10. Abaszadeh, Nigina, Gender Specialist with UNFPA, Handover notes, 5/26/13.
11. Abaszadeh, Nigina. Police Taking Action on Violence Against Women in Afghanistan, December 2011.
12. Annual Work Plans, 2010, 2011, 2012
13. Atlas Finance Reports, COGNOS and FACE forms, 2010, 2011, 2012
14. Bigby, Line. GBV Sub-Cluster, Hand-over notes, July 2013.
15. Comprehensive List of CP3 Indicators by Subject Area, Programme Level and Data Sources – review and comments, and Update on Review of CPAP Indicators, 2013.
16. Country Office Annual Reports, 2010 and 2012
17. Report to the Danish Government, Project Progress Report for Embassy of Denmark, Kabul Afghanistan, 2011, and Progress Update of December 2012 to June 2013.
18. *Population Situational Analysis for Afghanistan (PSA) Report*, September 2012, UNFPA.
19. *Fighting Early and Child Marriage in Afghanistan, A Harmful Traditional Practice*. UNFPA Gender Unit, 2012.
20. *Framework for Action on Adolescents and Youth*, global strategy, 2009
21. NEX Audits, 2010, 2011, 2012
22. *Strategy on Adolescents and Youth*, Global Strategy, February 2013
23. *Strengthening the Capacity of Afghanistan's National Police Force and Other Legal Actors Towards Addressing Violence Against Women and Girls*, Concept Paper.
24. Screening Protocol for Family-Based Violence (FBV) Survivors, October 2011.
25. Final Country Programme Document (CP3), 2010-2013, July 6, 2009.
26. UNFPA Country Office Annual Report (COAR) for Afghanistan, 2010, 2012.
27. Country Programme Action Plan 2010-2013, March 27, 2010.

Others

28. Afghanistan Independent Human Rights Commission. *National Inquiry on Rape and Honour Killing in Afghanistan*. Report Summary, 2013.
29. Altai Consulting, *Evaluation of UNFPA's 2nd Country Programme in Afghanistan, 2006-2009*, June – August 2010.
30. Hamid, Zarin. UNSCR 1325 IN-Country Monitoring Report Afghanistan, Afghan Women's Network. *FINAL - UNFPA Afghanistan Country Programme 3 (CP3) Evaluation – FINAL submitted Dec 29 2013*

31. Katie Harris, David Keen and Tom Mitchell, 2013 *When Disasters and Conflict Collide - Improving Links Between Disaster resilience and Conflict Prevention*, ODI, February 2013
32. IASC, *Implementation of the Gender Marker for 2012 in CAPs and Pooled Funds, Analysis of Results and Lessons Learned*, February 2012
33. Linda Lavender, "The Youth Bulge in Afghanistan: Challenges and Opportunities". Civil-Military Fusion Centre, October 2011, pages 1-6.
34. *Managing Gender-based Violence Programmes in Emergencies*, Australian Aid Government.
35. *Outlook Afghanistan, 1000 Cases of Violence Against Women in 3 Months*, Kabul, October 1, 2012.
36. *Trend Analysis of Afghanistan Key Health Outcome Metrics - Moving Toward MDG Targets – 2002-2011 – Donor Coordination Meeting*, powerpoint presentation prepared by William Brady, M&E Advisor USAID, April 2013
37. UN Common Country Assessment (CCA, 2013), Draft
38. UN Consolidated Appeal, Mid-Year Review, Afghanistan, 2012.
39. United Nations Development Assistance Framework, In Support of Afghanistan's National Development Strategy, 2010-2013.
40. UNDAF Mid-Term Progress Report of the UNDAF 2010-2013.
41. UNDAF, In Support of the Afghanistan National Development Strategy 2010-2013.
42. UNDP. Human Development Report 2013 for Afghanistan, *The Rise of the South: Human Progress in a Diverse World*, Explanatory note on 2013 HDR composite indices.
43. UNICEF Multiple Indicator Cluster Survey4 (MICS4), 2011
44. United Nations Office of the Commissioner, Opening remarks by UN High Commissioner for Human Rights Navi Pillay at a press conference during her visit to Afghanistan, Kabul, 17 September 2013.
45. Women, Peace and Security Research Institute. *Access to Justice is a Woman's Security*. A Baseline Study of the implementation of Elimination of Violence against Women Law (2009)

Annex 3 – CP3 Results Matrix - Planned and Actual Results

CP3 Expected vs. Actual Results

Expected results	Outcome Indicators	Actual Results
Reproductive Health		
<p>Outcome 1: By 2013, utilization of high-quality reproductive health information and maternal health and family planning services is increased in selected underserved provinces</p>	<ol style="list-style-type: none"> 1. % of births attended by skilled birth attendants (disaggregated by province) 2. Modern contraceptive prevalence rate (disaggregated by province) 3. National RH strategy operationalized 4. % of health facilities providing at least three modern methods of contraception 5. Fistula prevalence rate in focus provinces 	<p>(Data from targeted provinces and underserved regions not consistently collected as per the indicators in this matrix. Most data gleaned from surveys rather than collected from UNFPA targeted areas.)</p> <ol style="list-style-type: none"> 1. Nationally, significant progress has been made in the number of mothers who receive antenatal care which has already exceeded MDG 2020 goals (52.9% compared to 50%), who are attended by qualified skilled birth attendants (SBAs), approximately 39%⁶², and who seek post-natal care, but the levels by international standards remain very low. 2. Family planning prevalence is still low. Only 20% of married women aged 15-49 years of age use modern contraceptives. From 2003-2010, rate of use of modern contraceptive jumped from 10 to 20%.⁶³ Contraceptive use stood at 22.3% among married women aged 15-49 years of age, with 19.5% using a modern method. The low rate of use among youngest groups of married women (15-19 & 20-24 years), respectively 6.0 and 12.8%, how that contraception is more often used to stop as soon as a certain number of children are reached, than to postpone the birth of the first child. Use of contraception is highest among women 35 to 40 years of age (27.8%). Preferred method of contraception is the use of injectables and the pill.⁶⁴ 3. GoIRA has taken a decision to operationalize RH strategy, and interventions are being rolled out 4. 100% of health facilities in the country offer three methods such as Condoms, Oral pills and Injectables 5. In 2010, Obstetric Fistula (OF) prevalence was 0.4 percent among married women in 15-49 yrs in 6 provinces. There has been no end line study for measuring prevalence. According to a study in 6 provinces out of 34 in 2010, the prevalence of OF was 4 cases per 1,000 married women in the age group 15-4 who had given birth to one or more children.
<p>Output 1.1: Increased institutional capacity of the MoPH to perform its stewardship role in relation to ensuring the availability of and demand for quality reproductive health services</p>	<ol style="list-style-type: none"> 1. National RH strategy, including corresponding action plans, developed and costed 2. National RHCS Strategy and Plan of Action developed and costed 3. Donor RHCS coordination mechanism established 	<ol style="list-style-type: none"> 1. The CO provided support to the MoPH for the development of a Child and Adolescent Health Strategy (2010-2013). In 2013, a national consultant was recruited to update the Strategy and include a component on health as per the National Youth Policy. 2. The National Youth Policy provides recommendations in four areas: health, employment, education and participation. The upcoming update will be used to translate the recommendations made in the policy into the National Child, Adolescent and Youth Strategy. 3. There is national RHCS steering committee, headed by MoPH; Strategy development is in initial stages. An expanded donor coordination group in health sector has been established recently with USAID as a chair. Donor RHCS coordination would be taken up very soon.

⁶² UNICEF Multiple Indicator Cluster Survey4 (MICS4), 2011

⁶³ UNFPA Population Analysis of Afghanistan Report, September 2012, p. ii.

⁶⁴ UNFPA Population Situation Analysis of Afghanistan, September 2012, p. 13.

	<p>and operational</p> <ol style="list-style-type: none"> 4. % of provincial health directorates that apply the SPECTRUM and/or CHANNEL software 5. Evidence-based IEC materials on RHR developed and used for policy dialogue, advocacy and training. 	<ol style="list-style-type: none"> 4. No PHD is applying the software as supplies are continues to be managed by NGOs implementing BPHS in the provinces. The transition for handling supplies from NGOs to PHDs did not take place. 5. IEC material developed, such as video animations, brochures, fillip charts, pocket books, posters, Radio campaigns and TV spots. FP in Legacy of Islam translated and distributed for orientation of religious leaders.
<p>Output 1.2: Strengthened capacity of health facilities and service providers, with a focus on selected provinces, to provide antenatal and post-natal care, basic and comprehensive emergency obstetric care and fistula treatment</p>	<ol style="list-style-type: none"> 1. % of people above 12 years of age who know three danger signs during pregnancy and know where to access health facilities, including MHU and CMW, for reproductive health services 2. # of FHH within the catchment area of MHU 3. % of households with a family health plan in catchment areas of MHU 4. # of district administrations in selected provinces that have an emergency preparedness plan available that integrates RH and GBV 5. # of women who received successful fistula repair 	<ol style="list-style-type: none"> 1. No recent data during CP3 on adolescent KAP 2. 81 FHHs are functional in priority areas. Fariyab 100 percent, Bamyán 68 percent in other provinces not yet started 3. No data available 4. Work is underway for 8 district plans, a small percentage of the need 5. Obstetric fistula facility now operational in Kabul as part of Malalai Hospital. During the period 2010-2011, 61 obstetric fistula cases were treated. No data available. In addition 30 cases of Pelvic Organ Prolapse and 30 cases of Rectocele were treated. Success rate of OF-operations is above 80%.⁶⁵
<p>Outcome 2: By 2013, young women and men adopt healthy lifestyles.</p>	<ol style="list-style-type: none"> 1. Gender sensitive life skills based ASRH integrated into national curricula of primary schools, secondary schools, Madrasas and teacher training schools 2. % of women aged 16-24 who were married before 	<ol style="list-style-type: none"> 1. Integration of ASRH did not meet goals, some NGOs worked on this using their own funds. Teacher training school as per the outcome indicator did not go ahead 2. According to the NRVA-2007-2008, the mean age at first marriage is 17.9 years with 9% of girls being married before the age of 15.⁶⁶ More than 46% of Afghan women are married before the age 18 according to Afghanistan Multiple Indicator Cluster Survey 2010/2011 and more than 15% before age 15.⁶⁷

⁶⁵ UNFPA, Population Situational Analysis of Afghanistan, September 2012, p.21.

⁶⁶ UNFPA, Population Situational Analysis of Afghanistan, September 2012, p.9.

⁶⁷ UNFPA, Population Situational Analysis of Afghanistan, September 2012, p.35.

<p>Output 2.1: Increased availability of reproductive health information and life skills education at the community level, focusing on girls and boys both in and out of school, in the most underserved districts of the target provinces.</p>	<p>age 16 and 18</p> <ol style="list-style-type: none"> 1. % of young people who both correctly identify ways of preventing GBV, STI, including HIV, and who reject major misconceptions 2. % of teachers in catchment areas of MHU trained on and providing life skills training to students 3. % of communities with a trained peer educator promoting reproductive health knowledge 4. % of young people who can name at least three modern contraceptive methods 	<p>(As a step toward achieving the outcomes, the CO provided support to the MoPH for the development of a Child and Adolescent Health Strategy (2010-2013). In 2013, a national consultant was recruited to update the Strategy and include a component on health as per the National Youth Policy.)</p> <ol style="list-style-type: none"> 1. More than 90% of all married rural and urban women in Afghanistan know about a method of contraception (AMS-2010). On average, women are able to name 5 different ways how to limit their fertility; compared to 2003, when only 22% of rural women had ever heard of contraception.⁶⁸ 2. Teacher training school did not go ahead 3. In 2012, the CO together with MoPH (implemented by AFGA) started the operation of a toll-free Youth Health Line which continues to provide free counseling, information and referral services to approximately 2,500 young women and men per month. From 2010 to 2012, the CO supported the Deputy Ministry of Youth Affairs in running four Youth Information Centres (Kabul, Herat, Nangahar and Marzar) which provided life-skills based training on sexual and reproductive health. In 2013, the CO continues to support the Youth Information Centre only in Kabul (see AFGA quarterly reports). The three other Centres were closed due to lack of funding. From 2010 to present, the Office provides training on youth friendly health services to key health care providers in the target provinces (see AWP's). 4. No recent data during CP3 on unmarried people.
Population and Development		
<p>Outcome 1: By 2013, increased utilization of socio-demographic data for evidence-based decision-making and policy and programme formulation and monitoring in support of the Afghanistan National Development Strategy, at national and sub-national levels</p>	<ol style="list-style-type: none"> 1. Census data collected and processed, results published, analysed and disseminated 2. # of central government institutions, their provincial directorates, and district administrations, that practice evidence-based planning 3. # of sectoral plans based on disaggregated data by sex and age 	<ol style="list-style-type: none"> 1. Country still lacks a functioning population and vital registration system. Afghanistan house hold listing conducted in 2010 provided reliable data on the number of villages and households. These data will be used as inputs for mapping of enumeration areas required for the Socio demographic and economic survey. Likewise, the list is currently being used by CSO as a sampling frame for other household surveys such as the National Risk and Vulnerability Assessment Survey, Extended Programme on Immunization, etc. 2. Socio-Demographic and Economic Survey for Bamyan conducted in 2011 providing data on education, employment, fertility, age and sex structure, mortality, household and housing characteristics. The data is disaggregated by sex, age groups, and district so as to analyze in detail the differentials among men and women, young and elderly people, and the geographical distribution. Highlights disseminated in 2012. Final results in English, Dari and Pashto completed and for dissemination by end of the year. Socio-Demographic and Economic Survey data collected for Ghor and Daikundi provinces from September 2012 to Jan. 2013. Part of a six year plan to collect data province by province. Phase preceded by training and enumeration phases. 22.7% of data processors were women. Data processing completed, tabulation to start and expected to release the highlights by end of 2013. Preparatory activities currently on-going for the survey in Kabul, Parwan and Kapisa. Results expected to be available by end of next year. 3. In order to ensure maximum utilization of data, six research papers are lined up to start this year. CSO and concerned ministries will be part of this research team.
<p>Output 1.1:</p>	<p>1. Training, Research and</p>	<p>1. The Training, Research and Information facility on Population and Development Programme Document</p>

⁶⁸ UNFPA Situational Analysis of Afghanistan (PSA), September 2012, p.47.

<p>Improved availability and use of national and local data, disaggregated by sex and age, to formulate, implement and monitor policies and programmes</p>	<p>Information facility on Population and Development (TRIPOD) established and operational</p> <p>2.# of selected national government institutions and district administrations with skilled staff and tools to collect and analyse data, and disseminate socio-economic and demographic information</p> <p>3.Socio-economic, geographic and demographic information system for emergency preparedness and response in place</p>	<p>has been developed with a multi-year stage by stage approach to provide emphasis on population dynamics, statistics, and demography in the curriculum at Kabul University. Likewise, it included training modules for short term training of stakeholders in the collection, analysis, and dissemination of data. The efforts are ongoing to mobilize funds to support this academic project.</p> <p>2. Trainings are planned for provincial governor's staff; provincial development councils, district officials, and relevant sectoral ministries on how to use SDES data in the Provincial/District Development Plans. A soft copy of all the provincial/district data generated from SDES will be handed over to those main Govt. partners. A number of trainings were conducted for CSO staff in the areas of data collection, mapping, data processing and analysis. It is an ongoing process until 2016. CSO was also provided with the necessary equipment as part of infrastructure capacity building for the staff to properly collect process, analyze, and disseminate data.</p> <p>3. The SDES provincial, district and village level data for the completed provinces are to be provided to ANDMA (Afghanistan National Disaster Management Authority) for emergency preparedness and response planning. This is an ongoing process whereby data will be provided to the said agency as soon as the data generation is completed for each province. The survey will continue until 2016 to complete the data collection process for the whole country.</p>
<p>Outcome 2: By 2013, the development, planning and allocation of available resources prioritizes the needs of young people</p>	<p>% of the national development budget allocated to gender and youth implemented at national and provincial level</p>	<p>UNFPA is working closely with Govt. counterparts on the budget allocation. But until now the national budget has not yet been allocated for the gender and youth sector. UNFPA is supporting Govt. National Priority Programme for gender and youth jointly with other international community. The CO provided extensive technical and financial support to the DMOYA for developing Afghanistan's first National Youth Policy (submitted for cabinet approval).</p>
<p>Output 2.1: Strengthened capacity of institutions and stakeholders, at national and community levels, to advocate, formulate, implement, monitor and evaluate policies and programmes related to young people and gender issues</p>	<p>1.Planning, monitoring and reporting tools available for integrating gender and youth in development planning</p> <p>2.# of selected national government and district administrations with skilled staff to collect and analyse data, and disseminate information on gender and youth</p>	<p>1. The CO provided technical and financial support to the country's first participatory Youth Assessment Study aiming to better understand the youth situation, their needs, priorities, challenges (prepared by Samuel Hall Consulting, final draft currently under review). CO is currently finalizing a comprehensive State of Youth Report Afghanistan.</p> <p>2. Targeted capacity development of Deputy Ministry of Youth Affairs (DMOYA); equipment provided, training for the DMOYA staff and civil society provided inside and outside of the country. The CO is also providing training opportunities to members of youth networks. In 2011, the CO ran a "small grants programme" which supported a number of activities and programmes carried out by youth organizations.</p>
<p>Gender Equality</p>		

<p>Outcome 1: By 2013, an environment conducive to empowering women and eliminating gender-based violence is created in target provinces</p>	<p>1.# of communities with women-led community development fund</p> <p>2.# of communities with a justice mechanism that arbitrates women's complaints without contradicting Constitutional rights and International Human Rights Conventions ratified by the Government of Afghanistan</p> <p>3.Net enrolment rate of boys vs. girls</p>	<p>(Outcome unrealistic and indicators not updated.) A better formulation would have been: Increased awareness in target communities of GBA and appropriate GBV services (imams, hospitals, police, shuras, CHWs).</p> <ol style="list-style-type: none"> 1. No data cited on the community development fund 2. No data cited on the # of communities with a justice mechanism that arbitrates women's complaints (see details below on the police sector response activities) 3. The World Bank data shows an increase in the ratio of girls to boys from 61% in 2009 to 66% in 2011. With regard to MDG2 (universal primary education), the ratio of girls to boys in school shows a decline with the level of education (52% primary to 21% tertiary).⁶⁹ <p>(The following activities are seen to contribute to outcomes.) UNFPA has been supported the Gender Dept. of the MoPH to develop the concept for a model of coordinated response to GBV for Afghanistan.</p> <p>Health sector response to GBV. UNFPA established Family Protection Centres through Development of Model and SOP. UNFPA also trained health services providers and GBV Key Actors on GBV response.</p> <ol style="list-style-type: none"> a. Total 1500 Health services and GBV key actors are trained 650 Male and 850 Women. b. UNFPA also established GBV referral system between GBV key actors in order to provide appropriate services to the GBV victims. c. Capacity building of health services providers on GBV psychosocial counselling. d. 207 Women and 87 Male = total 294 (Midwives and Medical Doctors trained) <p>Police Sector response to GBV. UNFPA through development of the manual on Police taking action on violence against women, trained law enforcement bodies (Total 171 Judges and prosecutors 29 Women and 142 Male trained) to strengthen their capacity to address GBV while maintaining ethical standards in the target provinces of Bamyan, Daikondi, Kabul and Nangarhar.</p> <p>GBV Data collection UNFPA developed GBV data collection tools through technical and financial support of to MOPH.</p> <p>GBV Sub cluster UNFPA strengthened coordination and referrals mechanism among GBV key actors through the establishment of the GBV SCs (National and regional GBV SCs).</p> <p>Advocacy UNFPA developed tools on the elimination of early and child marriage and established a communication working group for the early and child marriage campaign. UNFPA also contributed in commemoration of international days.</p>
<p>Output 1.1: Increased participation of</p>	<p>1. "Healthy family, fortunate society" strategy</p>	<ol style="list-style-type: none"> 1. UNFPA supported MOHRA in the development of healthy family and fortunate society book. 2. Representation of women in Shuras and Community Development Councils is low at 20 and 36% respectively

⁶⁹ Afghanistan MDG 2010 Report

<p>women in decision-making that relates to healthy families and livelihoods, at household and community levels</p>	<ol style="list-style-type: none"> 2. developed and operational # of communities where women participate regularly in community health shuras and CDC 3. Gender-sensitive life skills and sustainable livelihoods training materials developed and used as supplementary teaching material in schooling in selected communities 	<p>against 70 and 68% for men. Religious leaders, Youth Groups, Health Shuras and Community Leaders and Community Health Workers are trained on the GBV prevention and response in the target provinces (Total youth trained 244, women 79 and male 145)</p> <p>Health shuras, community leaders and religious leaders : 180 Male and 123 Women total 303 trained</p> <ol style="list-style-type: none"> 3. Life skills training not undertaken as not part of UNFPA mandate.
<p>Output 1.2: Enhanced capacity of target communities to identify opportunities for women's involvement in family and community life, and to prevent, respond to and monitor gender-based violence</p>	<ol style="list-style-type: none"> 1. # of influential males who are against gender-based violence 2. "Ethics and Gender in Policing" curriculum developed and implementation strategy operational 3. Education material on population and development issues developed and integrated in primary, secondary and Madrasa education, and teacher training curricula 4. # of GBV survivors that received health or counselling services 5. GBV treatment protocol integrated into pre- and in-service training of health service providers 	<ol style="list-style-type: none"> 1. No data cited on #s of influential males 2. UNFPA developed and disseminated a special course and comprehensive manual: "Police taking action on Violence against women in Afghanistan". UNFPA trained 6 trainers (3 women and 3 men) who received TOT and in turned undertook 28 trainings involving NPA's staff, police cadets, district commanders, chief of Human Right and Family response Units; personnel and front-line police in Kabul, Nangarhar, Bamyan and Daikundi provinces. Up to date, 504 people trained, out of these 260 were female and 244 were male. There are 3 female and 3 male trainers in Nangarhar, while in Kabul there are 2 male trainers and 3 female trainers. 3. No data on this indicator 4. 112 women and girl patients received GBV assistance at the Family Protection Centres in Kabul and Jalalabad. Majority of the abuse was physical violence 80% or above, psychological abuse, 10-15%, and others (denial of resources, force marriage, early marriage). Only 4 cases of rape in Nangarhar. Up to date, 491 people trained, out of these 274 were female and 217 were male. There are 3 female and 3 male trainers in Nangarhar, while in Kabul there are 2 male trainers and 3 female trainers. <p>5. Multi-agency GBV response UNFPA started the initial efforts for integration of Health response to GBV in Afghanistan in 2011. For the first time the efforts to address the pervasive problem of GBV in Afghanistan were developed into a custom-made coordinated multi-agency GBV response system. In this connection the following achievements should be highlighted: Conduction of the Assessment of Services Provided to Victims of Gender Based Violence by State and Non-state Agencies in Nangahar, Bamyan and Kabul provinces commissioned by UNFPA. Based on the assessment findings UNFPA introduced country specific health response to GBV concept model and Standard Operation Procedures for full implementation in 2013; Inclusion of the Model into National Priority Programme on Health (NPP5) under essential package service component.</p>

Annex 4 – Suggestions for Programmatic Improvement

The following are suggested strategies, inputs and improvements to be used while planning the CP4 and are open to further discussion among stakeholders. They do not require a formal management response.

Relevance

RH:

1. Support surveys and studies:

- Conduct a KAP survey for the community understanding of causes of maternal mortality and obstetric fistula, and unmet need for FP and its reasons which can help to design more effective IEC and media campaigns for preventing obstetric fistula and promoting natural healing. Conduct a knowledge attitude and practices (KAP) survey of perceived infertility as well as assess prevalence and treatment of cases.

2. Support joint strategy development:

- **Produce the RHCS strategy and action plan** with MoPH and donors, especially the EU and WB, who currently have NGOs purchase the needed RH commodities for the BPHS (USAID purchases the commodities and distributes to the NGOs). This strategy should work towards achieving efficiency through economies of scale and good quality of purchased commodities through advocacy that the EU and WB shift commodity procurement from NGOs to joint MoPH / donor procurement.
- **Support AMA to develop its Midwifery Education and Faculty Development Strategy** and to support the implementation of the strategy and training of faculty members to create a cadre of midwives trained to the master's degree level in order to act as faculty for the bachelor degree program that is to be created with technical assistance of both UNFPA Afghanistan and Iran.
- **Advocate with the MoPH and donors to include the FHH+MST in the BPHS strategy** and to support the coverage of all remote un-served areas by FHH. UNFPA should provide technical assistance and provide lessons learnt on how to select and deploy CMW in order to have high retention in service to their communities.

3. Enhance support for CMWs -.

- **Assess the CMW's workload, determining strategies to resolve any probable heavy workload.** Conduct enumeration of the community to be served by age and sex when establishing FHH (IPs in collaboration with the communities). This will help determine the expected workload on the CMW as well as help in setting realistic coverage indicators.
- **Advocate and coordinate with the Ministry of Education, UNESCO and UNICEF to implement female literacy activities** so as to have educated females that can study midwifery and thus the establishment of a FHH in the village. In the short term UNFPA is advised to make an exception for communities without suitable candidates to be served by a CMW from a nearby village.

ASRH and YD:

- ##### 4. Conduct a secondary analysis of the MICs, mortality study and provincial surveys to capture the youth data and to identify gaps.
- Supplement this information with more specific assessments on early marriage including, for example, who are the decision makers and what are the major determinants. Then conduct specific surveys of youth with higher SRH risks such as those with multiple partners, sex workers, intravenous or other drug users to guide programming. With the MoPH and other partners, such as WHO, UNICEF, and AFGA, and based on the findings in the survey analysis described above, re-consider conducting the KAP assessment study on adolescent and youth SRH that was planned earlier, assigning sufficient funding to implement the study, to allow more effective targeting of activities. Determine the needs by age and gender, marital status and location.

HA:

5. **Conduct or continue to pursue discussions with ANDMA regarding the amendment or revision of the NDMP so that appropriate support is given to the districts** as they develop their plans to contain provisions for GBV and RH including the MISP and ERH units. Ensure that the contractors implementing the district level plans include GBV and RH in emergency information and list the contact details of health workers who have been trained in MISP in the Disaster plans

PD:

6. **Develop a 5 year and a 10 year resources support strategy to support institutional development of the CSO with motivational aspects to retain staff and promote CSO's leadership role in production and provision of data use, increasing the long term strategic approach and reducing ad hoc planning**
7. **Conduct periodic sampling surveys of potential data users** to track utility and issues in usage.

Effectiveness

RH:

8. **Expand successful capacity development interventions**
 - **Expand training for male involvement, Mullahs and religious scholars** on FP and RH issues such as early marriage, maternal health issues and the need for breastfeeding and spacing for child health as well as on GBV. Support activities following training that will reinforce training messages, such as promoting advocacy by Mullahs about RH issues with communities through the Friday prayer speeches as well as holding seminars or religious lessons with their local communities.
 - **Conduct refresher training for CMW** annually, especially on new services and upgrade her skills and knowledge as she is alone in the remote community. Refresher training will also motivate her. Conduct technical training for IP management staff as well as MST providers by the UNFPA to guarantee the quality of implementation and service delivery
 - **Evaluate and strengthen the AMA mentorship program** for midwives, and apply it to CMW in the FHH model.
9. **Work in conjunction with MoPH's IEC Department to conduct media campaigns** regarding FP in context of Islam, birth spacing and breastfeeding as well as on the various available modern contraceptive methods. Mass media campaigns should utilize sensitized Mullahs to RH issues in BCC to local communities and in the urban areas, especially targeting youth. Raise funds for conducting mass media campaigns on early marriage issues as well as pregnancy and postnatal danger signs and the need for skilled birth attendants. Target messages concerning the RH of adolescent and youth populations.
10. **Improve quality of the OF interventions:** Train more MMH physicians, who are committed to serving in basic obstetric fistula repair in the MMH as well as arranging training in advanced fistulae repair. Supply modern equipment, such as the laparoscope and cystoscope as well as training on their use, according to the surgical needs assessment that was performed earlier. Replicate the OF wards and surgical facilities in the provinces in order to detect OF as well as to conduct OF repair training in the provinces. This should be done in at least two more provinces to ensure more even geographic coverage.
11. **Build capacity of the MoPH to procure commodities as well as to manage pipeline, cold chain and warehouses.** UNFPA should provide needed technical assistance to strengthen capacity and to build governance structures. Strengthen and support a coordinated joint procurement according to the developed RHCS strategy and action plan.

ASRH and YD:

12. **Using the basis for RH support among religious leaders already created,** continue to place RH in religious textbooks, and enhance access for young women to RH advice through the female Mullahs especially in rural areas. To enhance the value of this intervention by religious leaders, it should be broadened to include full discussion of contraceptive methods and prevention of early marriage.

13. With the MoPH, first evaluate the YHL and YIC and peer counseling.

- Extend the health/help line to the provinces to allow the counselling and referral services to reach more youth and collect more data on prevalence of ASRH issues; Determine how counselling services on ASRH can reach rural areas, such as through the FHH and the MHU.
- Enhance Health Line counselor capacity for addressing gender specific psycho-social issues - Develop a question answer bank based on main problems of Afghan youth (e.g. after the KAP survey)
- Provide up to date telecommunication equipment that can handle the large volume of calls
- Re-consider the support design of the youth information centers, and if feasible continue the Y-peer counseling, using models and experience from other countries

HA:

- 14. Expand the district planning exercises** based on lessons learned when feasible to as many districts as possible ensuring that activities are well monitored.

PD:

- 15. Do more fund raising for the role-out of the SDES**, to move it more quickly to achieve the milestones, conducting the SDES in 34 provinces until 2016- exposure of new donors and build a strong donor coordination mechanism led by CSO Develop the CSO website (currently under development) to be user friendly and develop a digital application, to promote wider use
- 16. Increase awareness on data definition and data use** through more media exposure and more senior level conferences

GE:

- 17. Strengthen coordination and establish functioning referral mechanisms.**
- 18. Evaluate support to the Ministry of Haj** to ascertain effectiveness & impact of UNFPA support.
- 19. Consolidate and scale up GBV work with Family Protection Centres and Police Academy** especially in rural and remote areas

Efficiency

RH:

- 20. Expedite disbursements** as well as to fund the AMA for complete projects.
- 21. Negotiate with donors to provide funding that ensures continuity and cohesiveness within provincial strategies** to reach CP results.
- 22. Support reporting through the Channel software** as a government requirement, which will result in official standards and obligation to utilize the Channel software.

PD:

- 23. Maintain a well-established reporting system with donors** over the course of the implementation and keep them updated on any modifications in the plan or budget. Base consultations on bottom up communication at the program officers and technical staff levels first to inform the higher level of management in regard to progress and monitoring.
- 24. Ensure that enumerators/cartographers have enough funds for their lodging** to motivate them to stay on the job and produce high quality work - work toward more accurate estimations of fund allocation and budgeting for the SDES.

Sustainability

RH:

- 25. Evaluate the pilot FHH + MST + CME pilot project through a prospective study** where data is collected about the communities served, increasing coverage and utilization indicators, cost data as well as mortality cases. This study has to be done with ownership of the RHD, the M&E department as well as the Deputy Minister.
- Apply for funding for the most cost-effective complete model of FHH + MST. In order not to duplicate other development partner's efforts, UNFPA needs to work in other geographic areas.

- Submit proposals that provide a cost-effective model of service delivery; the number of proposed FHH to be established by the project has to be sufficiently large in order to conduct CME training efficiently.
26. **Conduct an organizational capacity assessment of AMA and OAM** to identify weaknesses and gaps and work on raising their capacity to enable them to apply for and conduct complete programs with UNFPA support, such as the mentorship program for midwives especially CMWs serving in FHH, which will result in effectiveness synergies in UNFPA programs as well as greater visibility of UNFPA in enhancing midwifery.
- **Continue technical assistance to support the establishment and proper functioning of the NMCA** according to the produced five year action plan. Advocate with donors to fund the physical establishment of the council as well as to finance its operation.

ASRH and YD:

27. **Assess capacity of the DMoYA and support a capacity building strategy.**
- Support creation of a commission to promote the legalization of the ANYP through, for example, a secretariat in the Ministry of Information and Culture.
28. **Promote government (MoPH) take-over of responsibilities for the help line** with support for counselors.

PD:

29. **Utilize the institutional memory of national staff involved in CSO 1979 census;** their valuable experience and expertise should be utilized and their knowledge should be enriched with modern statistical technology

Management

General, and Monitoring and Evaluation

30. **Foster internal and external coordination mechanisms:**
- **Maintain regular and active presence at planning and coordination meetings** to avoid loss of visibility and to promote the ICPD goals
 - **Urgent recruitment of new GBVSC Coordinator** to take up responsibilities of GBVSC sub-cluster or risk losing momentum of previous International Consultant Coordinator.
 - **Ensure that the internal transversal humanitarian assistance and youth cluster coordination mechanisms are regularly scheduled**
 - **Strengthening the formal forum for generating population data led by CSO** to avoid existence of parallel data collection systems. All efforts should be centralized and directed.
 - Raise awareness of UNFPA's Gender Programme among UN agencies
31. **Conduct internal human resources assessment to prepare for CP4 and expansion of activities.**
- **More fully utilize national expertise and consultants whenever possible** to build capacity and promote efficient use of funds.
 - **Programme HR Recruitment** with clear targets and indicators, closing the gender gap among staff at UNFPA; establish Gender Roster for UNFPA in key programmatic areas.
 - **Set out clear activities in TORS for technical advisors and consultants** that are regularly monitored with benchmarks for building capacity of the national staff as part of the deliverables. This will ensure the transfer of skills and knowledge to CSO staff.
 - Consider the potential of the Humanitarian Assistance focus, in view of the extreme vulnerability of the country, the limited coverage so far, and the work that can be done in light of the SDES results, and advise on whether the effort and staffing should be expanded.
32. **Develop an M&E Action Plan with Government that includes an M&E operating budget** to cover M&E database, surveys, joint field missions; and establish M&E group between UNFPA, Government and IPs to increase collaboration, conduct joint missions and learning opportunities and inform decision-making.

- **Conduct UNFPA M&E visits in coordination with the MoPH RHD and M&E Department** to enhance their stewardship role and to create ownership of the pilot FHH + MST model of service delivery. Train the district staff to provide supervision and monitoring the FHH (instead of the MSTs operated by IPs) as part of institutionalizing the FHH and its sustainability.
 - Develop and align M&E systems so they are results based for coherence in entire programme cycle starting with Project Design, Contracting, Collection of Baseline, Annual Work Plans tying results to indicators, Reporting by Results, and Using information for decision-making and learning
33. **Invest in RBM training** of UNFPA and counterparts (Government and IPs) on a regular basis and champion RBM starting at senior levels of management.
- Define for CP4 realistic results, targets and indicators.
 - Develop a results area for humanitarian assistance with its own indicators in the next CPAP; develop indicators specific to youth.

Strategic Positioning

34. **Strengthen transversal aspects.**
- **Create a separate and higher profile unit for Adolescents and Youth in the CO**, for the purpose of strengthening development of programme documents based on needs assessments and linkages to the other programmatic areas, and with its own budget and fund raising and coordination strategies that enhance visibility for UNFPA's efforts to promote youth SRH.
35. **Externally, strategically position UNFPA's youth programme among Ministries (e.g. MoPH, Youth Affairs, Education) and UN partners, especially UNDP and UNICEF**, and develop a joint strategy through consultation among programme staff and presentation of options to senior management including RH communications through the education system and other methods and promotion of the Youth Policy; Obtain APRO support for the internal youth programme strategy development.
- **Pursue stronger interventions for youth in less served focus areas, such as prevention of child marriage, adolescent pregnancies, youth drug users and other marginalized youth.**
 - Working in conjunction with the Ministry of Education and the MoPH, **launch ASRH in school curriculums and teacher training**, using the multiplier effect to reach thousands of youth, and/or promote and supplement the activities of those already doing so, such as AFGA's, to engage youth at an early age and prevent ASRH problems.
 - **Integrate ASRH in FHH setup using the FHH midwives as peer education trainer** and establish a small resource center in the FHH.
36. **Expand mandate to include Gender mainstreaming into other UNFPA programmes**
- **Expand the mandate and budget of Gender Equality** to include forced marriages; SRH among adolescent youth.
 - **More training and capacity building on humanitarian GBV prevention** and response and expansion of GBV activities to IDP camps.

Annex 5 - Reproductive Health KAP and BCC

Reproductive Health Knowledge, Attitude and Practice Survey and Behavioral Change Communication Campaign

A Knowledge, Attitude and Practice (KAP) Survey for RH related knowledge and beliefs is needed for Afghanistan, since there is a lack of such information for decision-making regarding designing interventions to address RH needs. The following discussion highlights gaps in information and the data that needs to be collected to help design and conduct a Behavioral Change Communication (BCC) Campaign. The KAP survey will serve as a needs assessment and baseline for the BCC Campaign: Data should be analyzed by age and sex to more efficiently target groups with relevant messages and through the appropriate means of communication.

Literature with detailed analyses on health-related problems in Afghanistan is sparse and appropriate questions need to address gaps in the analysis. For example, the AMICS (2010-2011) states that two-thirds of babies born at home are still born, however, the prevalent causes of the still births have not been ascertained. Ob/Gyn experts should suggest determinants of reproductive and pregnant women's behavior that may contribute to still births as well as maternal mortality and morbidity and design appropriate questions on the KAP survey.

In addition, there is a lack of data regarding, knowledge, attitudes and practices related to FP attitudes, reasons for unmet need, lack of appropriate spacing and FP during breastfeeding; as well as prenatal and post-natal danger signs. This data is crucial for designing appropriate interventions such as BCC campaigns to address women's RH issues. In addition, data is needed regarding community understanding of obstetric fistula, which can help to design more effective IEC and media campaigns for preventing obstetric fistula and promoting natural healing. It is recommended that UNFPA conduct a detailed KAP survey (see below data required) regarding all Afghanistan women's RH issues in order to address them through a mass media BCC campaign.

In conducting the BCC campaign, it is important to utilize different channels to reach the target population besides mass media. It is recommended that UNFPA extend its sensitization work for FP promotion with male physicians (male involvement), journalists, religious leaders and their wives nationwide and to other influential key actors as well as to extend to other needed health promotion topics, which would be identified by the KAP survey. For example, since early marriage is prevalent in Afghanistan, special BCC campaign activities should be addressed to adolescents in schools, out of schools, attending youth centers and associations etc. as well as through mass media messages concerning the importance of delaying marriage. Additional examples of influential key actors that can act as channels for raising-awareness of the population are medical, nursing and midwifery schools, civil society organizations such as youth and women's associations as well as community based structures such as CHWs, health Shuras and FHAGs.

The continuation of the sensitization of religious leaders to FP is recommended to expand to other topics such as early marriage, importance of spacing between children at least three years as a requirement of Quraan⁷⁰ and for children's health. UNFPA work with religious leaders should not stop at awareness-raising but should extend to devising activities for religious leaders to share in BCC activities addressing their local communities, through dedicating some Friday prayer speeches to women's RH issues. Also it is recommended that Religious Leaders hold community meetings with men to speak about such topics.

⁷⁰ The Quran states that children should be breastfed for a complete two years. Since pregnancy could occur during breastfeeding and is detrimental to both the baby and the quality of breast milk received by the infant. Then appropriate FP methods should be used to postpone pregnancy until after the two years. Thus the space between two children in the context of Islam should be at least three years.

Religious Leaders may be asked to give seminars in youth centers and in schools for adolescent boys and girls. Although most of Religious Leaders activities would target males, however, males are important decision-makers in women's reproductive health issues in Afghanistan.

The KAP Survey Data Needed:

Early marriage

- Optimum age at marriage
- Reasons for early marriage
- Influence of "religious" beliefs

FP

- FP users attitude towards use of contraceptive methods
- Reasons for discontinuation
- Reasons for non-use (identify the magnitude of influence of religious belief)
- Reasons for unmet need (identify the magnitude of influence of religious belief)
- Use for spacing and limiting
- Influence of "religious" beliefs

Breastfeeding Practices and Birth Spacing

- Breastfeeding and weaning practices
- Birth spacing attitudes and influence of "religious" beliefs
- FP during breastfeeding: knowledge and attitudes

Prenatal and Post-natal danger signs

- Knowledge of symptoms of danger signs
- Knowledge of still births related symptoms and practices
- Health-seeking behavior for symptoms

Reasons for not seeking maternal services

- Prenatal Care
- Post-natal Care
- Skilled Birth Attendant

Practices to address OF

- Practices at home to deal with OF symptoms
- Health-seeking behavior

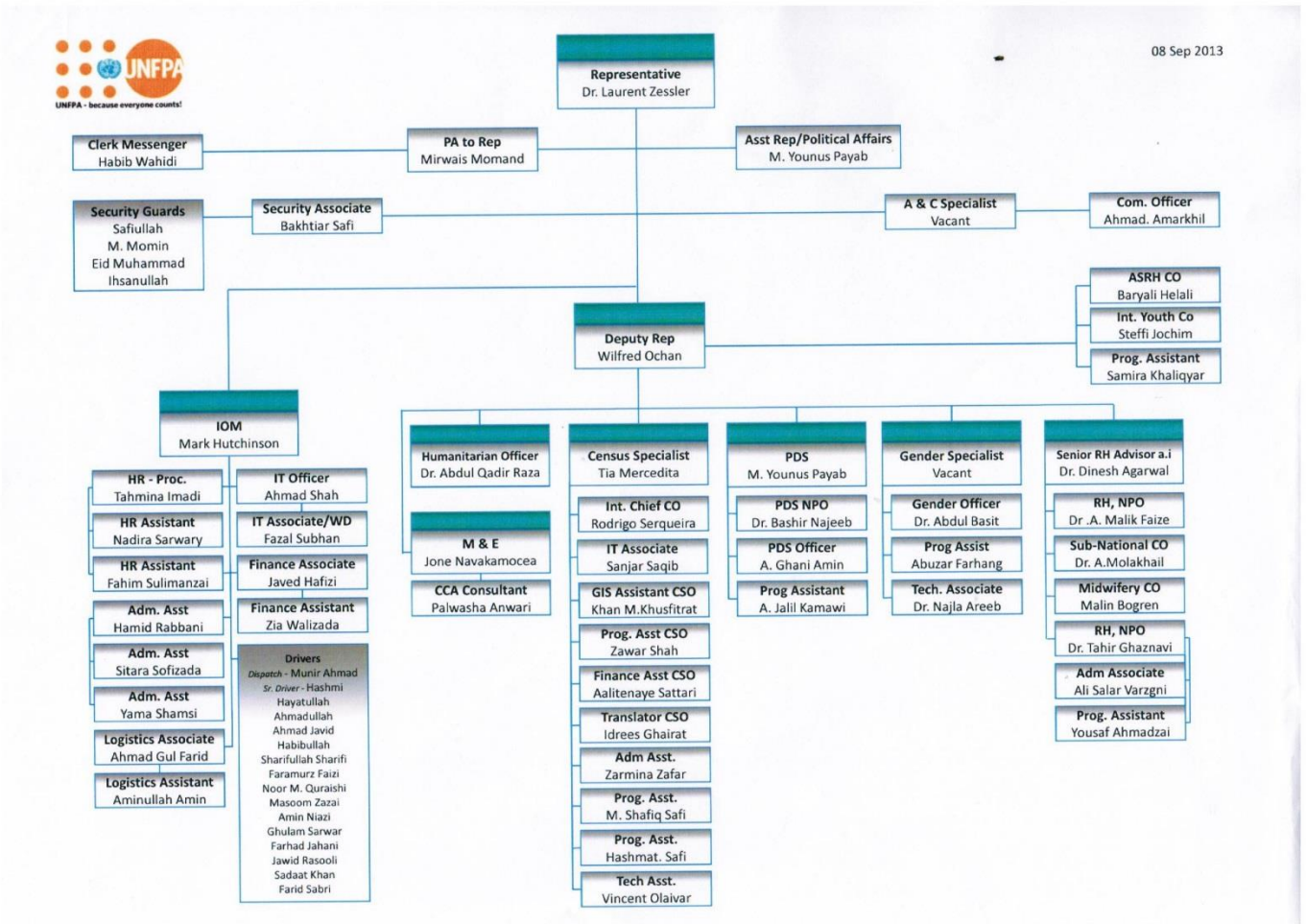
Decision-Making regarding RH issues

- Influence of males
- Influence of mothers and mother-in-laws
- Influence of "religious" beliefs

Sources of Health Related Information

- Mass media
- Religious Leaders
- Family members
- Health service providers
- CHWs, FHAGs and health Shuras

Annex 6 – Country Programme Organogram



Annex 7 – Terms of Reference

Evaluation of the Afghanistan Country Programme Cycle 3 2010-2013

1. BACKGROUND

The Country Programme Document (CPD) for the Country Programme Cycle 3 (CP3) was approved by the Executive Board of UNFPA and UNDP on 6th July, 2009 with a total budget of US\$38.8 million, of which US\$20.8 million was from regular resources and US\$18.0 million from non-regular resources. Total indicative budget for the CP3 of US\$38.8 million had declined by 34.0% when compared to the total indicative budget of CP2 (2006-2008) of US\$52.0 million. The decline was largely driven by a decline in non-regular resources by 127% from an allocation of US\$41 million in the CP2 cycle.

Resources in the programme were allocated amongst the three programme areas of Reproductive Health (RH) (54.1%), Population and Development (PD) (28.4%), Gender Equality (GE) (15.5%) and Programme Coordination Assistance (PCA) (2.1%).

The design of the CP3 was against a backdrop of rapidly changing political, security and development aid environment, wherein the international community and donors had marshaled their resources to aid Afghanistan for rapid political, social and economic reconstruction and recovery. The CP3 was largely drawn from the priorities in the Millennium Development Goals (MDGs), the global summit of 2005 and the national priorities identified in the Afghanistan National Development Strategy (ANDS). This also provided the platform for the development of the United Nations Development Assistance Framework (UNDAF) 2010-2013.

The CP3 was premised on the realization of human rights and enhanced participatory, gender and culturally sensitive approach in seeking to build the capacity of rights holders and duty bearers to improve the quality of life of the people of Afghanistan. In this connection and in partnership with the Government of Afghanistan and other key stakeholders, the CP3 focused on the following priorities:

- (i) Empower women and youth, girls and boys, with skills to achieve their dreams, think critically, negotiate risky situations and express themselves freely;
- (ii) Provide access to youth and gender friendly health services, including sexual and productive health information, education and commodities;
- (iii) Connect women and young people to livelihood and employment programmes;
- (iv) Uphold the rights of women and young people, specifically girls, to grow up healthy and safe;
- (v) Encourage women and young people to participate fully in the design, planning, implementation, monitoring and evaluation of development programmes; and
- (vi) Recognize the rights of women and young people to a fair share of education, skills, and services, with a special focus on economically disadvantaged, socially marginalized and vulnerable groups.

It is important to highlight that the CPD is aligned to the UNFPA Strategic Plan 2008-2011. It also defines the programmes contribution to the UNDAF 2010-2013. Importantly, the CP3 would contribute to the following priority areas in the in the UNDAF:

- (i) Governance, peace and stability (which is aligned to ANDS Sectors 1 and 2 and MDG 9 and 3);
- (ii) Sustainable livelihoods: agriculture, food security and income earning opportunities (ANDS sectors 3, 6 and 8; MDG 1, 3, 4, 8);
- (iii) Basic social services: health, education, water and sanitation (ANDS sectors 4, 5, and 7; MDG 2, 3, 5, 6 and 7).

Therefore, in alignment to the UNDAF 2010-2013, the following CPD outcomes were defined/developed for RH, PD and Gender Equality.

Reproductive Health:

- (i) Utilization of high quality RH information and maternal health and FP service is increased in target provinces;
- (ii) Young women and men adopt healthy lifestyles;

Population and Development

- (i) Increased utilization of socio-economic demographic data for evidence based decision making and policy and programme formulation and monitoring in support of the ANDS, at national and sub-national levels; and
- (ii) Development planning and allocation of available resources prioritizes the need of young people

Gender Equality

- (i) By 2013, an environment conducive to empowering women and eliminating genderbased violence is created in target provinces through the following strategies:
 - a. Policy dialogue and evidence based advocacy for establishing an enabling environment;
 - b. Gender sensitive, life skills based ASRH education and youth friendly SRH services
 - c. Research on youth dynamics; and
 - d. Participation of women and young people in decision making processes.

The CPD is operationalized through the Country Programme Action Plan (CPAP) 2010-2013 which highlights key outputs, implementation strategies and activities under UNFPA's three programme areas of RH, PD and GE and linking it to financial resources at different levels of results such as outcomes and outputs and identifies key partners to work with. The Results Resources Framework (RRF) contained in page 30 of the document, outlines relevant outcomes and outputs and respective outcome and output indicators against indicative budgetary resources (regular and non-regular resources) for the programme period 2010-2013.

The CPAP also outlines an M&E Calendar of activities and also the CPAP Planning and Tracking tool with respective baseline and targets annually for the plan period. The M&E calendar of activities is a source of data and information to populate the baselines and targets for indicators developed in the CPAP planning and tracking tool for tracking progress in project and activity implementation and to ascertain progress towards defined results in the CPAP RRF.

This is the final year of implementation of CP3 and to comply with the Executive Board's decision that each country programme should be evaluated at least once during the cycle, the Country Office will conduct the CP evaluation jointly with key partners in order to take stock of achievements, assess the sustainability of activities, compile lessons learned and propose recommendations to be considered and included in the development of the next CPD and CPAP.

2. OBJECTIVES OF THE EVALUATION

The overall purpose of the exercise is to produce a useful evaluation report, with a view to contributing to the elaboration of the next UNFPA country programme for Afghanistan.

The specific objectives of the independent evaluation of the UNFPA country programme for Afghanistan are:

- to provide the UNFPA country office in Afghanistan, national programme stakeholders, the UNFPA regional office, UNFPA headquarters as well as the wider audience with an independent assessment of the relevance and performance of the UNFPA country programme for Afghanistan;
- to provide an analysis of how UNFPA has positioned itself to add value in an evolving national context;
- to draw key lessons from past and current cooperation and provide a set of clear and forwardlooking options leading to strategic and actionable recommendations for the next programming cycle.

The major purpose of the evaluation is to assess progress in achieving the approved programme results, to provide insight into programme management and sector strategies to assess whether funds were utilized efficiently and effectively and to identify lessons learned and best practices. Lessons learned, best practices, recommendations and challenges from the evaluation will be fully utilized as key inputs to strengthen development of the CP4.

In addition, key findings from the evaluation will inform development of policies and strategies at Afghanistan Country Office. It is anticipated that the evaluation findings will also be shared with national counterparts, implementing partners, planners and decision makers.

The evaluation findings and results should provide guidance to the Afghanistan Country Office to strengthen planning, management, monitoring and evaluation in the context of results based management.

The key users of the evaluation findings and results would be the Country Office, IPs, government ministries, other UN agencies, donors, development partners and beneficiaries of the current programme cycle and potential partners in the next cycle. The evaluation findings and lessons learned could also be used by planners and decision makers in Government, IPs and donors to further enhance engagement, partnerships and collaboration in relevant areas and national priorities.

3. SCOPE OF THE EVALUATION

Coverage, time period, geographic area, programmatic aspects and target groups

This performance evaluation will focus on three thematic areas in RH, PD and Gender. While the evaluation will adhere to the rigor demanded in UN Evaluation Group and UNFPA evaluation standards and guidelines and ethics, the evaluation is being conducted in a conflict situation and full consideration will be given to the protection and wellbeing of the Evaluation Team members, evaluation participants and potential evaluation participants (those who could have participated if the security situation were normal). Security issues will restrict, for example, the evaluation team's access to specific types of information such as conducting group discussion or interviews outside of Kabul. These same security concerns may also limit some IPs travel to Kabul during the evaluation.

Under RH, the evaluation is expected to cover maternal health, family planning, reproductive health commodity security, adolescent sexual reproductive health (ASRH), youth friendly services and life skills opportunities, HIV and STI SRH linkages and humanitarian crisis.

Under PD, the evaluation is expected to cover and examine the net gains in the improved availability of quality and credible data at national and sub national levels and its utilization for advocacy, policy formulation, implementation, monitoring and evaluation of policies and programmes related to young people and gender issues. Furthermore, it will also examine whether capacity of institutions and stakeholders has been strengthened at national and community levels on the utilization of data and statistics to advocate, formulate, monitor and evaluate policies and programmes related to young people and gender issues.

Under GE, the evaluation will also cover and examine increased participation of women in decisionmaking levels that relates to healthy families and livelihoods at households and community levels. In addition it will also examine whether there has been increased opportunities for women's participation and decision making at family/household levels and community in preventing, responding and monitoring of gender based violence. Importantly, the strengthening of institutional structures in the Police Force and also in the health systems protocol to prevent, respond and monitor gender based violence will also be examined.

In order to make a realistic assessment of the net gains of project/programme and activity implementation and interventions, the evaluation will also examine programmatic interventions at national and sub-national levels, particularly of those underserved regions, districts and targeted communities.

The evaluation is expected to be conducted over three months (August, September and October) and will involve extensive consultations with IPs, government, donors, development partners and UN agencies and other relevant stakeholders in Kabul, Afghanistan. Depending on security the Evaluation Team may be able to visit select projects in targeted regions, provinces, districts, villages, and communities to ascertain the net gains of these projects/activities and interventions in their quality of life and development outcomes.

4.

EVALUATION CRITERIA AND EVALUATION QUESTIONS

- (i) In accordance with the methodology for CPEs as set out in the Handbook on How to Design and Conduct Country Programme Evaluations (2012) , the evaluation will be based on a number of questions (limited to a maximum of ten) covering the following evaluation criteria: Determine **relevance** of the outputs of the current CP3 to regional and national development priorities and strategies , the UNDAF, and UNFPA mandate, and rights holders;
- (ii) Assess the **effectiveness** of the Country Office activities/interventions during the CP cycle 2010-2013 in achieving targets;
- (iii) Evaluate the level of **efficiency** demonstrated during programme implementation in order to attain results identified during the programme cycle;
- (iv) Examine the potential **sustainability** of results by building local capacity in programme implementation;
- (v) Determine the level, nature and quality of **programme management, institutional partnerships and governance arrangements** within the Country Office and with implementing partners, government, relevant UN agencies, donors and development partners and other relevant stakeholders; and
- (vi) Determine the **internal and external strategic positioning of UNFPA Country Office programmes and interventions** through:
 - i. Review of the corporate and systems dimension to ascertain its alignment to the UNFPA Strategic Plan and UNDAF respectively;
 - ii. Review and ascertain its responsiveness towards changes in country needs and priorities and
 - iii. Review and ascertain its added value and synergies with other development partners

(i) Relevance

Relevance examines the extent of alignment of UNFPA's programme of assistance, policies and strategies, projects and activities to national priorities, policies and strategies and international agreements signed by the Government of Afghanistan such as the CEDAW, ICRC, MDGs and other human rights conventions. The assessment of relevance examines the degree to which outputs/outcomes in the CPD and CPAP are in accordance with national priorities and needs. Thus, in the criteria of relevance, please determine the following:

- (i) The extent to which UNFPA support to Afghanistan is aligned to the Afghanistan National Development Strategy (ANDS) 2008-2013; Are the strategies in the Country Programme relevant and responsive to national needs in Afghanistan, particularly in relation to maternal health and mortality, high fertility and population growth, gender based violence and violence against women, adolescent sexual reproductive health and youth employment and empowerment and humanitarian crisis;
- (ii) To what extent is the UNFPA support in RH, PD and GE (i) adapted to the needs of the population and disadvantaged groups and underserved populations (ii) and in line with the priorities in the internationally agreed development goals such as ICPD, MDGs, CEDAW and CRC etc. Do the planned interventions adequately reflect the goals stated in the CPAP?

(ii) Effectiveness

Effectiveness measures the capability of producing an intended result. Thus, it examines the extent to which planned results, including agreed outputs, outcomes and impacts are/were achieved as a

consequence of UNFPA Afghanistan Country Office's interventions and efforts. In this connection, the assessment of effectiveness examines the extent to which a programme/project achieves its planned results including outputs and outcomes. Thus, under the criteria of effectiveness, determine the following:

- (i) The extent to which the expected outputs of the CPAP were achieved or are likely to be achieved?;
- (ii) The extent to which technical assistance in RH (including RHCS and HIV), Gender and PDS contributed to more effective interventions at the country level?;
- (iii) The extent to which gender interventions in the CP have contributed (i) to raising awareness on gender based violence and (ii) positioning the theme on the national agenda?;
- (iv) The extent to which the CP has contributed to improved quality and affordability of SRH services and also on the management of delivery and of its complications, including the surgical repair of obstetric fistula?;
- (v) The extent of sufficient synergies amongst various programme components. Whether the sub-regional and national interventions contribute to and reinforce achievement of programme results e.g. What was the quality of the sub-regional and national programmes reaching youth? How did sub-regional interventions on the family health house (FHH) translate to increase ANC coverage, increased skilled birth attendants, safe deliveries and reducing maternal and infant mortality? How did sub-regional and national interventions with parliamentarians translate to increased national advocacy for PDS?

(iii) Efficiency

Efficiency examines how inputs (financial, human resources, technical and material resources) have been used economically and optimally to produce results (outputs). Thus in the assessment of efficiency, attempts are made to link outputs produced to resources expended and assess whether it was produced economically as possible. Does the quantity and quality of the results justify the quantity and quality of inputs used to produce them? Thus in the assessment of efficiency, determine the following:

- (i) How appropriately and adequately were the available resources (funds, staff and technology) used to carry out activities?
- (ii) The extent to which the intervention mechanisms (financing instruments, administrative regulatory framework, staff, timing and procedures) support or hinder the achievement of programme outputs?
- (iii) The extent to which UNFPA resources were focused on a limited set of core activities likely to produce significant results?

(iv) Sustainability

Sustainability considers the durability of positive results after a programme's completion or the end of UNFPA Country Office funding or support. It also examines the institutional and human resources capacity building during the programme intervention and whether sufficient and sustained capacity has been achieved to enable continuation of the programme without funding support from UNFPA Country Office. In the assessment of sustainability determine the following:

- (i) The extent to which stakeholders and implementing partners are willing and able to sustain programmes and continue activities on their own especially in terms of governance structures and programming and financial capacity;
- (ii) The extent to which stakeholders and implementing partners have institutionalized policies and strategies in the CP in their strategic plans and inclusion in their budgets;

(vi)

Country Programme Management, Institutional Partnerships and Governance Arrangements

Country programme management, institutional partnerships and governance arrangements considers the aspect of programme management and leadership in the office, implementation and monitoring and the partnerships, governance arrangements and coordination of the projects with IPs, government, donors and development partners and how it has contributed to the relevance, effectiveness, efficiency and sustainability of the projects/programmes. Thus, in the assessment of CP management, institutional partnerships and governance arrangements, determine the following:

- (i) The overall extent of programme management, planning, resource allocation, decision making, collaboration and implementation within the country office contributed to the achievement of results;
- (ii) The extent to which CO M&E system and tools were able to support programme management , implementation, decision making, resource allocation and contributed to the achievement of results;
- (iii) The level, nature and quality of coordination and collaboration internally and externally with relevant stakeholders, donors, development partners, IPs and government ministries have contributed to the achievement of results and sustainability of the programmes; and
- (iv) The extent to which the institutional partnerships and governance structures were able to support programme management, implementation and contributed to the achievement of results.

(vi) Strategic Positioning

Strategic positioning examines UNFPA programmes and interventions from the internal and external environment standpoint. Under the internal environment it considers the strategic alignment of its programmes and interventions from the corporate dimension through its alignment to the UNFPA Strategic Plan and framework and under the systems dimension, it considers its alignment to the system wide approach of the UN system as prescribed under the UNDAF for Afghanistan. From the external environment standpoint, it considers the responsiveness of UNFPA programmes and interventions to country needs and priorities and also the added value and synergies of UNFPA programmes to development partners working in the country. Therefore, in this context, under the assessment of strategic positioning, determine the following:

- (i) The extent to which the country office has positioned the ICPD goals and issues within government priorities, processes at national and sub-national levels;
- (ii) The extent to which the country office engenders national ownership, national leadership and national capacity development and its use of country systems and processes
- (iii) The extent of alignment of UNFPA programmes and interventions to the current UNDAF? Are there any gaps?
- (iv) Is the UNDAF fully inclusive of UNFPA interests, priorities and mandates? Can UNFPA confidently attribute the results of the UNDAF (Outputs & Outcomes that belong entirely to UNFPA) to its programmes and interventions?
- (v) Has UNFPA's programmes and interventions been responsive enough to the needs of communities given the ongoing changes in the political, security and humanitarian environments? What was the quality of response?
- (vi) What has been the main added value of UNFPA presence and its programmes in the country, given its comparative strengths?

5. EVALUATION METHODOLOGY

The evaluation will be a participatory process involving Country Office staff, beneficiaries, government, and implementing partners to continue to preserve the sense of ownership and set the stage to openly address issues and challenges and propose solutions or corrective measures to be addressed in the next CPD. A participative process will primarily focus on assessing progress towards the achievement of results and at the same time fostering an environment for learning and knowledge sharing.

The evaluation will follow UNEG norms and standards for evaluation (copy to be provided) as well as all UNFPA ethical guidelines, norms and standards. The evaluation team will jointly with the Afghanistan Country Office and other stakeholders, design the overall evaluation approach and data collection methods using a mixed method approach which includes a mix of qualitative and quantitative data collection methods and secondary data sources, to respond to the evaluation objectives and answer the evaluation questions. The evaluation methodology should highlight the following:

- List of key information sources i.e. UNFPA stakeholders (CO staff, partners, programme beneficiaries, both male and female)

- Measures to ensure that the evaluation addresses gender equality, human rights issues and vulnerable groups
- Sampling approaches for different data collection methods, including area and stakeholders to be represented, procedures to be used and sampling size, level of precision required
- Data collection instruments
- Data collection methods i.e. use of triangulation to ensure that the credibility of information gathered
- Types of data analysis
- Reference indicators and benchmarks where relevant
- Reporting and communication mechanisms during the course of consultation and discussion with UNFPA Country Office

The evaluation team should to the extent possible include in the design of the evaluation methodology the integration of gender and rights based approaches in the assessment of programme interventions and ensure that results have contributed to equality, participation, empowerment, social transformation and inclusiveness of gender, women and disadvantaged groups.

6. ETHICS

The CP evaluation will be conducted ethically, legally and with due regard for the welfare of the those involved in the evaluation, especially women, children and members of other vulnerable or disadvantaged groups and in accordance with the United Nations Evaluation Group (UNEGs) ethical guideline for evaluation. Due consideration will also be given to beneficiaries and other stakeholders on confidentiality of information and privacy during consultations and personal interviews.

7.

COMPOSITION OF THE EVALUATION TEAM (ET)

The CP evaluation will be undertaken by an interdisciplinary team of four Consultants⁷¹ with expertise or working experience in RH, PDS, Gender evaluation and/or programme design/programming and monitoring and evaluation.

The fourth member of the team should be a local national consultant with expertise in RH or PDS or Gender and/or programme design and monitoring and evaluation experience is a bonus.

The ET will comprise a team leader who can either also serve as RH or PDS consultant with expertise in programme design/programming and monitoring and evaluation and the other two members being experts in population and or gender consultants respectively.

The ET will work under the general guidance of the evaluation manager under the overall supervision of the Deputy Representative and/or Assistant Representative and in close collaboration with the M&E Specialist.

The members of the ET shall respect and abide by the rules stated in the UNEG code of conduct during the whole evaluation process. The UNFPA Country Office reserves the right to discontinue the contract of any team members if it feels that she/he does not live up to the expectations or does not respect the rules of the code of conduct or if she/he acts in a way that is detrimental to UNPFA's reputation and image.

The team leader is responsible for the final report (which should include an overview of the results of the CP3 and is to provide overall technical support and overview to the other consultants during the field research and writing of their respective reports. All four consultants should possess interview skills, analytical and facilitation skills and should also possess excellent English writing.

The profile of the ET is attached as **Annex 1**. It would be desirable if the team members collectively had expertise in RH, PD, Gender, programme design and M&E.

⁷¹ Attempts will be made to have gender balance in the composition of the team.

8. STAKEHOLDER PARTICIPATION

The success of the CP evaluation is very much dependent on full stakeholder participation, consultations and participatory evaluation that allows for meaningful participation of all programme partners, beneficiaries and other relevant stakeholders. Stakeholder participation forms a critical component of the evaluation design and planning, information collections, documentation of findings, development of the evaluation report and dissemination of the evaluation results and recommendations through a participatory workshop approach.

Therefore, in order to improve the quality of the next CPD and CPAP and to ensure that national and communities development needs are addressed, it is important to invite IPs and national counterparts to participate in the final evaluation of the programme. This will also increase the sense of ownership of programme activities and at the same time will ensure that programme activities and their impact would be sustainable.

The participation of the different stakeholders should be done at different stages of the evaluation process and should also be done separately as their interest and involvement in programme implementation is different. The methodology on how best to capture the views of the partners should be discussed during the inception meeting using as background document the evaluation questions.

The list of potential stakeholders for the consultations process will be drawn up and circulated.

9. EVALUATION MANAGEMENT – ROLES & RESPONSIBILITIES

The Evaluation Manager – Roles and Responsibilities

The evaluation will be managed by the M&E Specialist (Evaluation Manager). The Evaluation Manager will be responsible for the following key roles:

- (i) Overall coordination of the evaluation roles and responsibilities with Consultants/Evaluation team;
- (ii) Provide overall guidance and quality assurance on every process of the CP evaluation;
- (iii) Facilitate the Consultants/Evaluation team's access to background documents;
- (iv) Coordinate UNFPA COs internal review processes;
- (v) Coordinate and arrange for the services and other assistance that UNFPA will be able to provide to the team such as provision of office space, computers, telephones and other logistical arrangements;
- (vi) In consultation with the ERC approve all evaluation deliverables.

Evaluation Reference Committee (ERC) – Roles and Responsibilities

The evaluation will be managed by an ERC comprising of the following staff:

- (i) Senior Representative from Government (Co-Chair)
- (ii) Dr Laurent Zessler – Representative (Co-Chair)
- (iii) Representative from another UN agency
- (iv) Representative from Ministry
- (v) Representative from Academia - University
- (vi) Representative from NGOs
- (vii) UNFPA M&E Advisor

The ERC will be responsible for the following roles and tasks:

- (i) Provide overall technical guidance and quality assurance on every process of the CP evaluation;
- (ii) Review and endorse the CP evaluation terms of reference;
- (iii) Recommend the TOR to the Representative for approval and for subsequent submission to APRO and DOS for review and approval in accordance with UNFPA evaluation guidelines;
- (iv) Short listing, selection and endorsement of consultants/evaluation team; (v) Review and endorse inception report; and (vi) Review and approve evaluation report.

Evaluation Management Group – Roles and Responsibilities

The evaluation will be managed by an Evaluation Management Group (EMG) comprising of the following staff:

- (i) Mr Younas Payab – PDS Advisor/Asst Rep (Chair)
- (ii) Jone V Navakamocea – M&E Specialist (Evaluation Manager)
- (iii) Ms Tia Mercedita – Census Specialist
- (iv) Dr Prasanna Gunasekera – RH Advisor
- (v) Dr Nigina Abasszade – Gender Advisor
- (vi) Dr Amhadullah Molakhail – RH Sub Regional Programme Officer
- (vii) Mr Mark Hutchinson – International Operations Manager

The Evaluation Team will work in close collaboration with the Evaluation Manger, but report to Deputy Representative.

10. EVALUATION WORK PLAN

The workplan spells out the roles and responsibilities of all those involved in the CP evaluation. It details all specific tasks to be undertaken, the deliverables as well as the time lines involved.

Annex 2 outlines key activities, persons responsible, outputs and timelines of the work plan. The Gant Chart outlining detail activities, timelines and responsibilities of relevant staff has been developed and will be used internally for the purposes of scheduling and implementation of CP evaluation activities.

The CP evaluation is expected to take place during the months of August, September and October, 2013. The number of working days by each consultant is temporarily set at **66 working days** and will be distributed among the different phases of the evaluation process depending on their involvement in the completion of specific tasks and/or activities. The level of effort will also vary depending on the role of the consultant i.e. team leader versus team member and the consultancy fee will be set accordingly to reflect level of effort and responsibilities.

11. DELIVERABLES

Following the review of the proposed TOR and relevant documents of the CP 2010-2013 and discussing the evaluation with Afghanistan Country Office, the team leader should submit an Evaluation Design Report. The design report in a nutshell should briefly describe the Evaluation Team's understanding of the CP evaluation, its objectives, scope, the country and programme contexts, the UNFPA strategic response and programme and evaluation methodological approaches and framework and evaluation processes and their work plan in partially responding to the CP3 evaluation TOR. It also provides a clear indication of how the Consultants/Evaluation Team view and understand their tasks and plans to achieve the objectives of the evaluation.

Therefore, within **7 days** of the award of contract, the Evaluation Team Leader shall submit an electronic copy of a draft design report to UNFPA Country Office Evaluation Manager. The design report provides an opportunity for UNFPA Country Office and the Consultants/Evaluators to ensure that their interpretations of the TOR are mutually consistent. The Evaluation Manager will coordinate the internal review and approval of the design report from the ERG and the UNFPA Representative, and APRO which will serve as an agreement between UNFPA Country Office and the Consultants/Evaluators on how the evaluation shall be conducted.

The ET will be remunerated according to the following schedule: (a) 20 percent of payment upon completion of a satisfactory inception report; (b) 30 percent upon successful completion of field work; and, (c) 50 percent upon submission of a satisfactory final report.

The outline of the design report is contained in **Annex 3**.

The Consultants/Evaluators shall make oral or written presentation/briefing of the design report to the Afghanistan Country Office and its stakeholders. The Evaluation Manager shall obtain written comments on the design report from the ERG to the Consultants/Evaluators within 5 days of the report's submission or completion of the oral presentation, whichever comes later. The Afghanistan Country Office reserves the right to modify the TOR in response to the inception report.

Draft Evaluation Report

The evaluator shall submit an electronic copy of a draft evaluation report to UNFPA's Evaluation Manager no later than 26th September, 2013. The draft report should be thoroughly copy edited to ensure that comments from UNFPA and other stakeholders on content, presentation, language, and structure can be reduced to a minimum.

The Consultant/Evaluator shall make a debriefing presentation to the UNFPA Representative and other relevant staff on the submission of the draft evaluation report.

After UNFPA Country Office and stakeholders' review of the draft report, the Evaluation Manager shall coordinate written comments on the draft report from UNFPA Country Office, stakeholders, including other UN agencies, and in-country partners and shall submit these to the Consultants/Evaluators. Based on these comments, the ET shall correct all factual errors and inaccuracies and make changes related to the report's structure, consistency, analytical rigor, validity of evidence, and requirements in the TOR. The ET will not be required to make changes to conclusions and recommendations unless they are regarded as qualitative improvements. After making the necessary changes, the ET will submit a revised draft evaluation report, which may lead to further comments from UNFPA. After the second round of review and, if necessary, further revision to the draft evaluation report, the ET can then submit the final report pending UNFPA Country Office's approval. The draft evaluation report will also be shared with APRO for their review and comments on the quality of the report as per established UNEG guidelines and standards.

Final Report

The recommended structure of the final report is provided as Annex to this TOR and the Consultant/Evaluator should follow this as closely as possible. The report must contain a self-contained executive summary that provides a clear, concise presentation of the evaluation's main conclusions and key recommendations and reviews salient issues identified in the evaluation. All deliverables must be in English. The main body of the report should be a maximum of 30 pages plus annexes. The recommendations must be limited to 5 to 8 prioritized recommendations. While the final set of recommendations is the sole responsibility of the Evaluation Team, the CO would like to work with the evaluation team during a half-day session to discuss, refine, clarify and make actionable each recommendation, as deemed appropriate by the Evaluation Team.

12. DOCUMENTATION

Reference documents listed in **Annex 5** will be made available to the Consultants/ET to enhance background knowledge of the CP3 and facilitate the evaluation.

13. LOGISTICAL SUPPORT

The UNFPA Country Office will arrange consultation meetings with relevant staff in the office. In addition a timetable/schedule of consultations will also be drawn up outlining key partners and stakeholders for consultation regarding the evaluation which would include relevant government ministries and departments, IPs, donors, development partners, community leaders, and relevant UN agencies. The UNFPA Country Office at UNOCA Compound will be the base for the ET and where the team would meet twice or more depending on need, during the evaluation process: at the beginning of the evaluation to clarify role and methodology, agree on the TOR and stakeholders and to prepare the Evaluation Inception Report and also at the end of the evaluation to present the findings and report of the evaluation. During their stay in UNOCA the ET will visit and meet partners, donors, beneficiaries and stakeholders that are based in Kabul as part of their in-country meetings and interviews.

The M&E Specialist with the assistance of relevant staff in the office will also organize travel and consultation of the ET to implementing partners in the districts/provinces and regions and communities and visit some of the projects to ascertain for themselves how the projects is progressing and how it is

impacting the communities. The ET will be fully briefed by the ERC on the evaluation TOR, evaluation schedules, travel and logistical support and what to expect in-country.

Due to security situation in Kabul, the ET will be provided official transport to enable them to travel and hold consultations with IPs, government ministries/departments and communities.

Members of the ET will be offered a Special Service Agreements (SSA) contract with specifications on the number of days of work, the daily consultancy fee and honorarium, the maximum amount to be paid and the modality of payments.

The ET will be expected to work five (5) days a week. Travel to the districts/provinces and regions, where necessary will be organized by the UNFPA Country Office. The UNFPA Country Office will make available office space, however members of the ET will be expected to bring their own laptops.

All documents for review by the members of the ET will be posted/uploaded in DocuShare under the Afghanistan Country Office knowledge platform.

Where required and if considered necessary, the ET will be supported by a Programme Assistant during the duration of the evaluation who will provide logistics and administrative support related to the conduct of the CP evaluation.

14.

EVALUATION BUDGET

The funds to conduct the CP3 evaluation have been sourced from regular resources and have already been allocated. The budget will cover the following:

- (i) The Consultant's fees based on number of days worked and the agreed daily honorarium.
- (ii) The cost of all international travel including return tickets, DSA and terminals;
- (iii) Costs of travel locally to the provinces/regions for consultations;
- (iv) Any other incidentals directly related to the evaluation such as telephone calls, printing, faxes.

The budget to be estimated based on number of days – duration of consultancy for the evaluation, consultancy rates for each evaluation team members.

Annex 8 – Data Collection Tools, Survey and Methodological Instruments

Survey Questionnaire Compilation UNFPA Country Programme Evaluation

Sex:

Total for Bamyan: Male: 7 Female: 9 Total: 16

Total for Kabul: Male: 11 Female: 4. Total: 15

Total: 31 respondents. Male: 18 Female: 13

Representing:

___10___ UNFPA;

___5___ Government of Afghanistan

___2___ Civil Society

_____ Donor

___11___ Other: In Bamyan from Shehada Org; IMC; Movement of Afghan Women, MOVE, IP AgaKhan

Please respond to the following questions:

1. Have you ever received training supported by UNFPA?

Bamyan: 14 ___yes_ 1 ___no.

Kabul: 8 yes and 6 no

If, yes, what was the training called?

Bamyan: Data entry, surveyor training, controller training, ToT Youth Friendly Services

Kabul: ToT for Health Response to GBV, Programme and Project Mgmt., Using Census Data in National Development Planning, Multimedia Communication Training, ToT Communication for development

How would you rate your satisfaction with this training?

Bamyan:

4 ___very high 26.6%

8 ___high 53.33%

2 ___medium 13.33%

1 ___low 6.66%

Kabul: -2- _2___very high 22.22%

_6___high 66.6%

_1___medium 16.66%

_____low

What skills and tools did you learn from this training?

GVB

Human Rights and GBV

How to interpret data in the computer

Interview Skills

How to use survey forms, How to guide surveyors

How to categorize mental health patients

Information about reproductive health
 Information about family planning
 Information about sexual transmission and treatment
 Communication skills
 Kabul: GBV, SOP
 Project Cycle Management, LFA
 How to conduct census of population
 Learned to manage a video-photo camera and edit it in Adobe
 -learned international experiences on population and development issues
 -learned about the data disaggregated analysis
 -Learned how to develop effective TOR for CPD Evaluation

What impact did this training have on your personal and professional life?

- Self-confidence and friendship
- Improve knowledge
- -better diagnosis of the patient and treatment
- ToT of Youth Friendly services. I know more information about RH, Population, Communication and sexual; transmission.
- Knowledge gained helped me to know more about the pop. Census processes
- I have applied evaluation criteria to the CPAP evaluation.
- -it refreshed my knowledge of cohort component method of population projection.

On a scale of 0-5 with one being low and 5 being high, to what extent did technical assistance in Reproductive Health contribute to more effective interventions at the country level?

0 1 2 3 4 5

Bamyan: 20% of resp. 30% 40% 10%

Kabul: 16.6% 33.33% 50%

Or ____ don't know

Please provide any examples:

Youth Helpline Clinic Services

FHH: Cap. Building of MOPH; Mid-wifery training

FHH: Providing RH services in remote areas

Training midwives and treatment of fistula for free

3. On a scale of 0-5 with one being low and 5 being high, to what extent did technical assistance in Population and Development contribute to more effective interventions at the country level?

0 1 2 3 4 5

62.5% 37.5%

Kabul: 10% 50% 30% 10%

Or ____ don't know

Please provide any examples: HR, Capacity of MOYA Youth Policy, and Youth Helpline

4. On a scale of 0-5 with one being low and 5 being high, to what extent did technical assistance in Gender contribute to more effective interventions at the country level?

0 1 2 3 4 5

Kabul: 28.6% 14.3% 28.6% 28.6%

Or ____ don't know

Please provide any examples:

-Police training –

-One stop health centres

-One of the very good interventions is the Health Sector Response to GTBV. It is a good opportunity for victim of GBV when they are coming in hospital for health services they can ask for other assistance.

5. On a scale of 0 to 5, what is the extent that the Country Programme improved the quality and affordability of Sexual Reproductive Health Services?

0 1 2 3 4 5

16.6% 50% 16.6% 16.6%

Kabul: 50% 50%

Or _____ don't know

Please provide any examples:

-Providing counseling services to youth through youth

-Helpline in Kabul and provinces

6. To what extent has UNFPA supported gender interventions contributed to raising awareness on gender based violence?

0 1 2 3 4 5

16.6% 66% 16.6%

Kabul: 16.6% 33.33% 50%

Or _____ don't know

Please provide any examples:

1. To what extent has UNFPA supported gender interventions contributed to positioning the theme of gender on the national agenda? –

2. 0 1 2 3 4 5

33.33% 66.6%

Kabul: 28.57% 28.57% 42.85%

Or _____ don't know

Please provide any examples:

-I have learned about GBV and gender.

-Conduct of man and women participation in decision-making survey

-age-sex disaggregation of data of provincial and district levels for policy-making and decision-making.

8. What has been the main value added of UNFPA presence and its programme in Afghanistan?

Health, Gender, Population, Capacity-building of implementers, Training and improvement of professional staff

-Help the population to access health services in Bamyan

-Community involvement and ownership

-UNFPA had a lot of useful programmes in Afghanistan; it was in centre of every province but not in village of Afghanistan.

-Training and Improvement of Professional Staff

Kabul:

-UNFPA supports very important programmes in Afghanistan, such as capacity-building in GBV

-Built government capacity

-established infrastructure -6-

- data availability endeavours started at provincial level and will be rolled out to all of the country
- resource mobilization
- Improving RH
- Providing SRH service and information to adolescent + youth
- Putting adolescent and youth issues on the national development agenda.
- Improving SRH services in Afghanistan
- UNFPA supported MOIU (Gender and Human Rights) and capacity building of their staff
- Health sector response to GBV
- Police sector response to GBV.
- UNFPA is working on GBV and response of health service providers for GBV victims. When victim of GBV goes to the hospital or health clinic, service providers asked them to bring official letter that we can provide health services by implementing this programme and conducting many batches of training as well as advocacy by government people . Now are changes.
- UNFPA are working on GBV with Policy. It is very important given Afghanistan situation as well because police is the person who is doing-punishment and implementing rules and regulations on perpetrators of GBV.
- I think it is capacity building particularly to CSO. Thru these capacity-building programmes, the CSO should be able to implant its mandate (data provision) on its own.
- The main value of UNFPA in Afghanistan is:
 - to provide health services through MOPH;
 - work for Gender GBV throughout the selected provinces;
 - SDES survey and youth programmes.

Interview Guides

Interview Guide with the UNFPA Country Representative

Overview Questions:

1. What have been the key achievements of CP3?
2. Have there been limitations you would like to outline for CP3?
3. How has CP3 added value given evolving national context?
4. What have been the key lessons learned from the past and current cooperation?
5. Are there any best practices you would like to highlight?
6. What have been the net gains of project/programme and activity interventions in RH; in PD and GE?
7. What have been the net gains for programmatic interventions at national and sub-national levels, particularly in underserved regions, districts and targeted communities?
8. What have been the net gains in terms of quality of life and development outcomes?

The Evaluation Questions

1. *Relevance*

- 1.1. To what extent and how is UNFPA's support to Afghanistan is aligned to the Afghanistan National Development Strategy (ANDS) 2008-2013?
- 1.2. Are the strategies in the Country Programme relevant and responsive to national needs in Afghanistan, particularly in relation to maternal health and mortality, high fertility and population growth, gender based violence and violence against women, adolescent sexual reproductive health and youth employment and empowerment and humanitarian crisis?;
- 1.3. To what extent is the UNFPA support in RH, PD and GE (i) adapted to the needs of the population and disadvantaged groups and underserved populations (ii) and in line with the priorities in

the internationally agreed development goals such as ICPD, MDGs, CEDAW and CRC etc. Do the planned interventions adequately reflect the goals stated in the CPAP?

2) Effectiveness

- 2.1. What are the key results of the CP? What is the extent to which the expected outputs and outcomes of the CPAP were achieved or are likely to be achieved?;
- 2.2. To what extent has technical assistance in RH (including RHCS and HIV), Gender and PDS contributed to more effective interventions at the country level?;
- 2.3. To what extent has gender interventions in the CP have contributed (i) to raising awareness on gender based violence and (ii) positioning the theme on the national agenda?;
- 2.4. To what extent has the CP contributed to improved quality and affordability of SRH services and also on the management of delivery and of its complications, including the surgical repair of obstetric fistula?;
- 2.5. To what extent are there sufficient synergies amongst various programme components?. Whether the sub-regional and national interventions contribute to and reinforce achievement of programme results e.g. What was the quality of the sub-regional and national programmes reaching youth? How did sub-regional interventions on the family health house (FHH) translate to increase ANC coverage, increased skilled birth attendants, safe deliveries and reducing maternal and infant mortality? How did sub-regional and national interventions with parliamentarians translate to increased national advocacy for PDS?

3. Efficiency

- 3.1. Does the quantity and quality of the results justify the quantity and quality of inputs used to produce them?
- 3.2. How appropriately and adequately were the available resources (funds, staff and technology) used to carry out activities?
- 3.3. To what extent do the intervention mechanisms (financing instruments, administrative regulatory framework, staff, timing and procedures) support or hinder the achievement of programme outputs?
- 3.4. The extent to which UNFPA resources were focused on a limited set of core activities likely to produce significant results?

4. Sustainability

- 4.1. To what extent do stakeholders and implementing partners willing and able to sustain programmes and continue activities on their own especially in terms of governance structures and programming and financial capacity;
- 4.2. To what extent do stakeholders and implementing partners have institutionalized policies and strategies in the CP in their strategic plans and inclusion in their budgets?

5. Country Programme Management, Institutional Partnerships and Governance Arrangements

- 5.1. To what extent do programme management, planning, resource allocation, decision making, collaboration and implementation within the country office contribute to the achievement of results?
- 5.2. To what extent do CO M&E system and tools able to support programme management, implementation, decision making, resource allocation and contributed to the achievement of results;
- 5.3. What are the level, nature and quality of coordination and collaboration internally and externally with relevant stakeholders, donors, development partners, IPs and government ministries and how have they contributed to the achievement of results and sustainability of the programmes? ;
- 5.4. The what extent do the institutional partnerships and governance structures support programme management, implementation and contributed to the achievement of results.

6. Strategic Positioning

6.1. To what extent did the country office position the ICPD goals and issues within government priorities, processes at national and sub-national levels?;

6.2. To what extent did the country office engender national ownership, national leadership and national capacity development and its use of country systems and processes

6.3. To what extent do UNFPA programmes and interventions align to the current UNDAF?

Are there any gaps?

6.4. Is the UNDAF fully inclusive of UNFPA interests, priorities and mandates? Can UNFPA confidently attribute the results of the UNDAF (Outputs & Outcomes that belong entirely to UNFPA) to its programmes and interventions?

6.5. Has UNFPA's programmes and interventions been responsive enough to the needs of communities given the ongoing changes in the political, security and humanitarian environments? What was the quality of response?

6.6. What has been the main added value of UNFPA presence and its programmes in the country, given its comparative strengths?

Future:

1. The CP3 was largely drawn from the priorities of the MDGs, the global summit of 2005 and the national priorities identified in the Afghanistan National Development Strategy, UNDAF. What do you feel are the key influencing factors and documents influencing CP4?

2. What kind of future options would you like to see for the CP4 based on experience to date and why?

Interview Guide with Government

Overview Questions:

1. What have been the key achievements of CP3?
2. Have there been limitations you would like to outline for CP3?
3. How has CP3 added value given evolving national context?
4. What have been the key lessons learned from the past and current cooperation?
5. Are there any best practices you would like to highlight?
6. What have been the net gains of project/programme and activity interventions in RH; in PD and GE?
7. What have been the net gains for programmatic interventions at national and sub-national levels, particularly in underserved regions, districts and targeted communities?
8. What have been the net gains in terms of quality of life and development outcomes?

The Evaluation Questions

1. Relevance

1.1. To what extent and how is UNFPA's support to Afghanistan aligned to the Afghanistan National Development Strategy (ANDS) 2008-2013?

1.2. Are the strategies in the Country Programme (focus on RH, Population and Development, Gender Equality) relevant and responsive to national needs in Afghanistan, particularly in relation to maternal health and mortality, high fertility and population growth, gender based violence and violence against women, adolescent sexual reproductive health and youth employment and empowerment and humanitarian crisis?;

1.3. To what extent is the UNFPA support in RH, PD and GE (i) adapted to the needs of the population and disadvantaged groups and underserved populations (ii) and in line with the priorities in the internationally agreed development goals such as ICPD, MDGs, CEDAW and CRC etc. Do the planned interventions adequately reflect the goals stated in the CPAP?

2) Effectiveness

2.1. What are the key results of the CP? What is the extent to which the expected outputs and outcomes of the CPAP were achieved or are likely to be achieved?;

RH:

1. As a result of UNFPA support, what has been the availability of and demand for high quality family planning services in target provinces?
2. What are the priorities of the national reproductive health strategy?
3. How has UNFPA supported the implementation of the national reproductive health strategy?
4. How have service providers at health facilities within target provinces been strengthened to provide antenatal and post natal care, basic and comprehensive emergency obstetric care and fistula treatment?
5. How has birth spacing (through education and behaviour change modification) been promoted and has it been effective?
6. How is the availability of reproductive health information and life-skills education at the community level, focusing on boys and girls both in and out of school, in the most underserved districts of the target provinces?
7. How effective are the mobile health units?
8. Are women and men adopting healthy lifestyles? What do they consist of?

Population and Development:

1. How is the availability and use of national and local data, disaggregated by sex and age?
2. Is this data used to formulate, implement and monitor policies and programmes?
3. How is the data used for the development, planning and allocation of available resources and for prioritizing the needs of young people?
4. Has the capacity of institutions and stakeholders at national and community levels been strengthened to advocate, formulate, implement, monitor and evaluate policies and programmes related to young people and gender issues?
5. How has the capacity of the Government been strengthened to monitor the MDGs and Afghanistan National Development Strategy in assessing changes in key population issues?
6. How has understanding been improved regarding importance of incorporating population dynamics, reproductive rights and gender into national policies and plans?
7. How has the capacities of the Ministries of Public Health, Education and Youth been strengthened to use participatory approaches?

Gender Equality

1. How has been the participation of women in decision-making that relates to healthy families and livelihoods, at a household and community levels? Can you be specific?
2. How has capacity been enhanced of target communities to identify opportunities for women`s involvement in family and community life, and to prevent, respond to and monitor gender based violence.
3. What has been your experience in training religious leaders, community elders to advocate the benefits of family and community of women`s empowerment
4. How effective has been the design of life skills curricula aimed at vulnerable women and girls?
5. What types of grass roots initiatives have been supported at preventing Gender based violence?
6. How has the legal knowledge of customary law, court officers at the community level been built?

2.2. To what extent has technical assistance in RH (including RHCS and HIV), Gender and PDS contributed to more effective interventions at the country level?;

2.3. To what extent has gender interventions in the CP have contributed (i) to raising awareness on gender based violence and (ii) positioning the theme on the national agenda?;

2.4. To what extent has the CP has the CP contributed to improved quality and affordability of SRH services and also on the management of delivery and of its complications, including the surgical repair of obstetric fistula?;

2.5. To what extent are there sufficient synergies amongst various programme components?. Whether the sub-regional and national interventions contribute to and reinforce achievement of programme results e.g. What was the quality of the sub-regional and national programmes reaching

youth? How did sub-regional interventions on the family health house (FHH) translate to increase ANC coverage, increased skilled birth attendants, safe deliveries and reducing maternal and infant mortality? How did sub-regional and national interventions with parliamentarians translate to increased national advocacy for PDS?

3. Efficiency

3.1. Does the quantity and quality of the results justify the quantity and quality of inputs used to produce them?

3.2. How appropriately and adequately were the available resources (funds, staff and technology) used to carry out activities?

3.3. To what extent do the intervention mechanisms (financing instruments, administrative regulatory framework, staff, timing and procedures) support or hinder the achievement of programme outputs?

3.4. The extent to which UNFPA resources were focused on a limited set of core activities likely to produce significant results?

4. Sustainability

4.1. To what extent do stakeholders and implementing partners willing and able to sustain programmes and continue activities on their own especially in terms of governance structures and programming and financial capacity;

4.2. To what extent do stakeholders and implementing partners have institutionalized policies and strategies in the CP in their strategic plans and inclusion in their budgets?

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5.1. To what extent do programme management, planning, resource allocation, decision making, collaboration and implementation within the country office contribute to the achievement of results?

5.2. To what extent do CO M&E system and tools able to support programme management, implementation, decision making, resource allocation and contributed to the achievement of results;

5.3. What are the level, nature and quality of coordination and collaboration internally and externally with relevant stakeholders, donors, development partners, IPs and government ministries and how have they contributed to the achievement of results and sustainability of the programmes? ;

5.4. The what extent do the institutional partnerships and governance structures were able to support programme management, implementation and contributed to the achievement of results.

6. Strategic Positioning

6.1. To what extent did the country office position the ICPD goals and issues within government priorities, processes at national and sub-national levels?;

6.2. To what extent did the country office engender national ownership, national leadership and national capacity development and its use of country systems and processes

6.3. To what extent do UNFPA programmes and interventions align to the current UNDAF?
Are there any gaps?

6.4. Is the UNDAF fully inclusive of UNFPA interests, priorities and mandates? Can UNFPA confidently attribute the results of the UNDAF (Outputs & Outcomes that belong entirely to UNFPA) to its programmes and interventions?

6.5. Has UNFPA's programmes and interventions been responsive enough to the needs of communities given the ongoing changes in the political, security and humanitarian environments? What was the quality of response?

6.6. What has been the main added value of UNFPA presence and its programmes in the country, given its comparative strengths?

Future:

1. The CP3 was largely drawn from the priorities of the MDGs, the global summit of 2005 and the national priorities identified in the Afghanistan National Development Strategy, UNDAF. What do you feel are the key influencing factors and documents influencing CP4?
2. What kind of future options would you like to see for the CP4 based on experience to date and why?

Interview Guide with Donors

1. What has been your involvement with UNFPA's programme-project activities?
2. What kind of synergies exist between your organization and UNFPA?
3. Can you provide examples of joint collaboration?
4. Do you feel that UNFPA's programme fills an important niche in Afghanistan?
5. What do you feel is the value added of UNFPA in a country, like Afghanistan?
6. Do you see any future strategic directions for UNFPA?
7. Do you have any recommendations?

Interview Guide with Community Stakeholders

1. What has been your involvement with UNFPA programme-project activities?
2. For you, what has been the most significant changes as a result of UNFPA support?
3. Can you be more specific in terms of key results in RH, Population and Development and Gender Equality?
4. How has capacity at the community and district level been promoted? Has emergency preparedness and response capacity-building been promoted?
5. How have you adopted healthy lifestyles?
6. Has demand and utilization for health care services in RH by women, youth, internally displaced persons, returnees, deportees, nomads and other marginalized population groups increased since 2010?
7. How has your involvement in UNFPA supported activities improved your life?
8. What have been the constraints in project implementation?
9. How can programme activities continue after the end of the programme in 2013?

Annex 9 – Outputs of “Participatory Dialog on CP3 and Future Directions” Workshops

Bamyan Workshop with key Project Stakeholders, September 14, 2013				
Key Results of the Various Programmes				
S/No	Gender	PDS	RH	
1	Public awareness on Gender and GBV has gone up	Capacity Building of Administrative staff	Awareness about birthe spacing and use of modern family planning methods	
2	Most of the women self-reliance has gone up	Assessed level of literacy and education in Bamyan	Misconception about diseases and their treatment	
3	Violence against women has reduced substantively	Determined the number (population)of Bamyan	Increasing of the awareness and practice on personal and environmental hygiene	
4	Working outside home was taboo in past, now women know their rights of working	Assessed the sourced of income in Bamyan	Maternal and child deaths establishment of family health houses and presence of CHWs	
5	The women can decide to run in election and give vote to who ever Girls to choose their future spouse	Assessed economic situation of people and villages	Increasing the awareness of vaccination and its utilization	
6			Establishing RH trainings Capacity building of midwives Supply of quality health services Reducing the mortality rate of children and mothers	↑ Increasing Capacity of health workers with training
7			Establishment of family health houses Access of each women to health services and health centers	↑ Access to health centers in remote areas run by midwives

			Public awareness on health issues	
8			Training of midwives on FHH from remote areas and sites Permanent service for ever provided to people	Involvement of community in CHC and selection of midwives, good impact on mortality rate ↓
9			Having mobile team Access of people to health services Taking advantage of pregnant women and children under 2 years from vaccination Public awareness	7 mobile team in provinces Will have good impact on mortality rate
10			Strengthen of local health shoras and FHH Safe delivery of children in FHH referred by health shora Raising the level of awareness of people through Family Health Action Group(FHAG)	Community based health shoras, CHWs health education health care ↑

Beneficiaries

S/No	Lesson Learned	Future challenges
1	Raising the level of awareness of people of health issues	Security
2	Importance of the Existence of health centers	Mobile coverage areas
3	Have the right information of the community situation	Terminating of UNFPA programmes

S/No	Strengths	Weaknesses
1	Existence of family health houses	Lack of accommodation in FHH
2	Existence of mobile team	No specific salary(rate) for the surveyors
3	Existence of house to house survey	Non Availability of salary for CHWs
	Awareness of health issues	
Strategies for overcoming of these weaknesses		
1	Assigning another person	
2	At the beginning of operation salary should be specify	
3	For the motivation of CHWs their salary should be designated	

S/No	Best Practices	Recommendation
1	Proper House to house survey	Expansion of health services
2	Having monthly meeting in order to solve peoples problems	Conducting long terms capacity building courses for health workers in community level
3	Awareness of the importance of health	Gender awareness on community level
4	Proper implementation of first aids in right time	Establishment of effective programs for youth and all people of community in the areas.

Sustainability , what is needed to ensure local capacities in program implementation	
1	Program should be based on the need assessment of community
2	Involving of people of the community in programs
3	Existence of capacity building programs for employees
4	Implementation of programs effectively
5	Investment on youth for future

Gender Stakeholders

S/No	Lesson Learned	Future challenges
1	Awareness of gender issues	Security
2	Eliminating violence	Low level of the economy of families
3	Access to their rights	Unemployment
		Lack of law enforcement

S/No	Strengths	Weaknesses
1	Raising the level of awareness of male and female	Lack of programs and remote areas
2	Reduction of violence	Low level of education(literacy)
3	Awareness of their rights	
Strategies for overcoming of these weaknesses		
1	Conduction of Sustainable workshops on community level	
2	Establishment of literacy trainings for people in villages	

S/No	Best Practices	Recommendation
1	Conducted workshops on violence against women	Expansion of workshops in all remote areas
2	Gender and development	Capacity building and ability of people
3	Gender based violence	Raising the confidence of people
4		

Sustainability , what is needed to ensure local capacities in program implementation	
1	Conduction of workshops in remote areas and support from shelter house
2	Creating a business occasion for continuing vocational training for women
3	Establishment of literacy trainings for women awareness

PDS Stakeholders

S/No	Lesson Learned	Future challenges
1	Coordination between donors and implementing agencies	Recruitment of capable staff
2	Payment of salaries on time	Consumption of time for those employee assigned in mountains areas
3	Time management and also considering the area and geographical status of the areas and type of employment	Timely monitoring and evaluation of the projects

S/No	Strengths	Weaknesses
1	Successfully implementation of projects	Time limitation for the implementation of the project
2	Capacity building of staff	Weak trainers and non-familiarity of areas for cartographers
3	Having the whole information and data of Bamyán	Lack of monitoring and lack of Tools and Features

		Donors did not Maintain working relationship
Strategies for overcoming of these weaknesses		
1	Trainers and other staff should recruit from their own province	
2	Enough time to be given for the implementation of project	
3	Tools and Features to be provided on timely bases	
4	Strengthen of supervisors and their feeling of responsibilities	

S/No	Best Practices	Recommendation
1	Registration of information and figures and life situation in province	Number of female employee to increased
2	Getting the right data and compilation of the projects successfully	Improve the quality of trainings
3	Recruitment of staff from their residential areas	
4		

Sustainability , what is needed to ensure local capacities in program implementation	
1	Programs to be implemented based on the need assessment of each area and city
2	Capacity building trainings to be provided to implementers
3	Project to be selected based on the need assessment of peoples
4	Partnership of the people in projects
5	Implementation of planning and evaluation

RH Stakeholders

S/No	Lesson Learned	Future challenges
1	Partnering the community is the strength of programmes	Continuation of projects
2	Training of local midwives	Raising the awareness level of community trough awareness campaigns in provincial and district level
3	Services in remote areas	Referral problems in the hospital
4	Existence of mobile team	

S/No	Strengths	Weaknesses
1	Existence of trained and expert midwives in RH	Staff problems
2	Access to health services in remote areas	Lack of coordination
3	Having information and data	Short terms projects
4	Existence of enough sources	External monitoring is not enough
Strategies for overcoming of these weaknesses		
1	Renewed the structure of FHH team	
2	Sharing UNFPA programmes with all health organization working in same area	
3	Extension of programmes for long term	

S/No	Best Practices	Recommendation
1	Partnering the community	Long term projects
2	Establishment of FHH	Establishment of shelter house based on the need assessment
3	Training of midwives	More mobile team to be recruited
4		More training to be provided to midwives
5		Involving community in all programmes

	Sustainability , what is needed to ensure local capacities in program implementation
1	Raising awareness of health shoras and resident of the areas trough workshops in the province

Workshop with Kabul Stakeholders, September 17, 2013

Each programme identified 5 key impacts as a result of UNFPA support

S/No	Youth	Gender	PDS
1	Access to ASRH services (information, counseling and referral)through help line in Kabul and provinces	Strengthen coordination mechanism between GBV actors and (medical, Psychosocial legal and safety shelter actors)	Capacity building of CSO staff(data collection, Data processing and survey design) Human resource, GIS, and dissemination)
2	Increased capacity and empowerment of youth on RH,HIV,STI and Gender through Peer education programme	Some behavior change among men and women 70% violence decreased	Physical Infrastructure (Motor bike, Communication equipment's, generators, GIS UPS ,c computers, Vehicles Building and printing process) Building, Training rooms, Data processing center and GPS
3	Increased the institutional capacities of Gov counter parts and IPs through workshops and trainings	Case identification increased due to functionalizing of one staff assistant center (OSAC)or FPC	Data dissemination, awareness, publicity campaign to the survey users and stake holders, Donors, government planners, Data center on SDES data at village level.
4	Increased confident of youth on utilizing youth health services	Capacity development of GBV actors and health workers (data collection, referral and SOP)	Support coordination with stake holders , ministries, donors and local government
5	Increased awareness of the need of adolescent and youth (policy, advocacy and research)	Manual reference between all actors specially with police and GBV actors	Availability of data for planning and decision making Availability of sampling frame, data for small areas, estimation + planning , list of all house hold to be used for sampling frame and utilization
6			Enable service provision for future services in Afghanistan(survey , Census and documentation)
7			CSO generation of sex disaggregated data(training of female enumerators)

Gender Stakeholders

S/No	Lesson Learned	Future challenges
1	More Capacity development needed for IPs and health workers (2 dots)	Low cooperation of health sectors with GBV implementing partners (2 dots)
2	Involving of religious leaders Community has a good result (2 dots)	Low commitment of the Gov
3	Adopt international GBV concepts top Afghanistan context (2 dots)	Misinterpretation of the GBV in Afghanistan (1 dot)
		Harmful tradition practices

S/No	Strengths of Gender Programme	Weaknesses of Gender Programme
1	Good Coordination between actors (1 dot)	Sometime UNFPA interferes with small implementation mater (2 dots)
2	Financial support of the actors	Turnover of GBV staff in UNFPA (one dot)
3	Community participation encouraged	Imbalance in budget line items (2 dots)
	Health sector activated in response to GBV (3 dots)	
Strategies for overcoming of these weaknesses		
1	Specific MOU should be followed by both donors and implementing agencies (1 dot)	
2	Staff commitment should be motivated (1 dot)	
3	At proposal the budget for all lines should be well calculated and agreed	

S/No	Best Practices	Recommendation
1	Health sector involvement in GBV (3 dots)	Extend the duration of GBV intervention to get behavior change (2 dots)
2	Police capacity building in GBV (3 dots)	Expansion of the programme to provinces
3	Working with religious leader (6 dots)	Explanation of FPC services in laboratory, FP and emergency Care (1 dot)
4		Gender roster
5		A group of professionals

	Sustainability, what is needed to ensure local capacities in program implementation of long term viability of the programme
1	Improve capacity of national staff to take the ownership and responsibility of GBV activities (leadership, management, response to GBV and gender budgeting) (6 dots)
2	Building the capacity of Gov partners to mobilize resources (one dot)
3	Advocate to Gov to include to include to elimination of GBV in NPP

Youth Stakeholders

S/No	Lesson Learned	Future challenges
1	Poor coordination	Security
2	Lack of coherence	Acceptance
3	Strengthen stake holder engagement (1 dot)	Access
		Resource Mobilization (one dot)
		Staff retention (one dot)

S/No	Strengths of Youth Programme	Weaknesses of Youth Programme
1	Capacity building relevance of UNFPA mandate in the Afghan context	Poor programme coherence, Continuity
2	Need based and targeted intervention (one dot)	Limited programme coverage (1 dot)

3	Relevance of UNFPA mandate to Afghanistan context (2 dots)	Limited focus on BCC (Behavior Change) (1 dot)
Strategies for overcoming of these weaknesses		
1	Strengthen coordination mechanism among stake holders (Gov, IPs, UN and Donors) (4 dots)	
2	Focused on communication strategies (one dot)	
3	Develop programme documents that integrate different component related to youth (4 dots)	
4	Programme expansion (2 dots)	

S/No	Best Practices	Recommendation
1	Help line counseling (7 dots)	UP scaling the best practices (4 dots)
2	Peer Education (3 dots)	Gender sensitive youth programme (2 dots)
3	YAP concept (1 dot)	
4	Youth consultation (2 dots)	

Sustainability , what is needed to ensure local capacities in program implementation of long term viability of the programme	
1	Capacity building of local communities institution
2	Long term vision and intervention
3	Advocacy (2 dots)
4	Owner ship (1 dot)
5	Involvement of stake holders (youth, Local community Etc)in programme and policy design and implementation
6	Promote available local resources and its utilization.

PDS (1) Stakeholders

S/No	Lesson Learned	Future challenges
1	Plan for adequate time and strategic anticipation of activities through early planning and coordination (two dots)	Security access
2	Strong training needed for monitoring (data Collection and data processing) (3 dots)	Low education and qualification of personnel
3	Good coordination with local authorities well ahead of data collection	Coordination with local authorities

S/No	Strengths of PD	Weaknesses of PD
1	Availability of adequate fund and resources	Slow payment to field staff (three dots)
2	Provision of strong technical assistance in (survey design, mapping) (4 dots)	Weak financial management
3	Strong targeting(strategic) for CSO and survey	Logistic problem ,delivery of survey materials and poor deployment of people
	Strong coordination between UNFPA and CSO (2 dots)	Accessibility problem
Strategies for overcoming of these weaknesses		
1	Used alternative ways of payment through (Hawala, private companies)	
2	More human resources to find	
3	Early planning and contracting of logistical companies for the shipments of materials (5 dots)	

S/No	Best Practices	Recommendation
1	Availability of institutional infrastructure (2 dots)	Use technical support to build capacity of CSO not to do the work separately (3 dots)
2	Well defined projects objectives (3 dots)	Hire qualified personnel through a strong human

		resources policy
3	Deployment of UNFPA to CSO (one dot)	Better coordination by UNFPA and CSO
4	Enhanced coordination with donors (2 dots)	Better utilization of CSO field office personnel through provision of infrastructural and training (1 dot)

	Sustainability , what is needed to ensure local capacities in program implementation of long term viability of the programme	
1	Continues trainings according to CSO capacity building strategy (three dots)	
2	Availability of qualified and committed personnel (at All levels) (one dot)	
3	Increased motivation through job promotion and training abroad (one dot)	

PDS (2) Stakeholders

S/No	Lesson Learned	Future challenges
1	Difficulties in data collection identified(recruitment, training, data processing, enumeration and others)	Security (2 dots)
2	Use of local people especially in secured areas	Funds
3	Collaboration between stake holders and CSO is very important	Brain drain (2 dots)
4	Ownership of survey by CSO (one dot)	Political environment (3 dots)
5		Geographical climate and condition
6		Technical capacity at the national local levels (one dot)
7		Cooperation of local government (2 dots)

S/No	Strengths	Weaknesses
1	Physical infrastructure built (2 dots)	Some indicators difficult to measure (One dot)
2	Human resources capacity increased (3 dots)	Low analytical capacity of staff(one dot)
3	Data availability (2 dots)	Poor communication between HQ and provincial offices (2 dots)
4		No presence of district offices
5		Lack of qualified staff
	Strategies for overcoming of these weaknesses	
1	Simplify the indicators (one)	
2	Continues capacity building (human and physical infrastructure) (one dot)	
3	Provision of communication equipment's and facilities (internet& Phone) , Improve communication mechanism between HQ and provincial offices (one dot)	
4	Advocacy campaign to establish district offices	
5	Develop incentives mechanism to attract qualified staff (one dot)	

S/No	Best Practices	Recommendation
1	Transparency in the recruitment	Continuation of technical and financial assistance (3 dots)
2	Collaboration with stakeholders (one dot)	Improve collaboration with stake holders
3	Cooperation of community leaders	Improve collaboration with community leaders (one dot)
4	Well prepared survey instruments (one dot)	Introduction of data collection
5	Use of GPS for quality control and coverage	Develop HR policies to retain and attract qualified staff (2 dots)
6	Data processing follows international	Improve communication mechanism between HQ

	standards (one dot)	and provincial offices (2 dots)
7		Advocacy campaign to establish District offices

	Sustainability , what is needed to ensure local capacities in program implementation of long term viability of the programme	
1	Advocate for additional Gov fund for statistical activities	
2	In-house training (training of the trainers) (2 dots)	
3	Advocate for participation and contribution of ministries and local government (1 dot)	
4	Maintenance of equipment, facilities (1 dot)	
5	Develop appropriate communication, HR, Data dissemination, data security policies and strategies	
6	Advocate for the establishment of district offices	
7	Improve international standards compliance (one dot)	
8	Awareness on data importance and use	

