

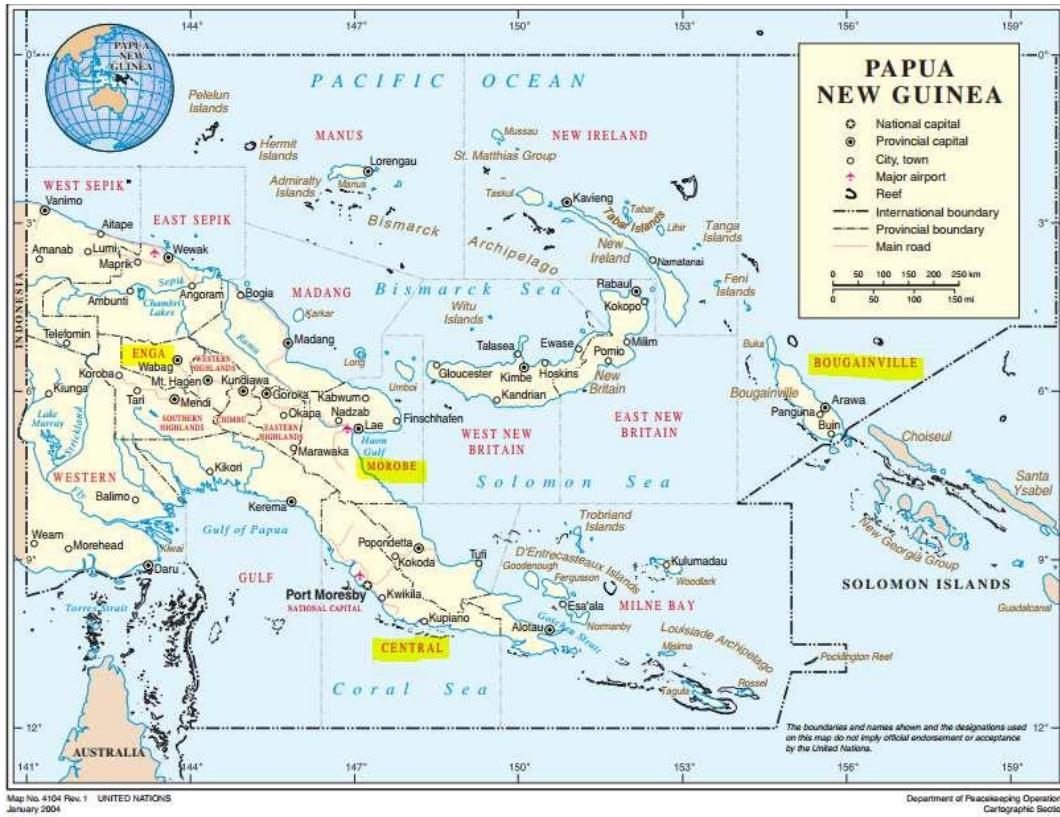
**UNFPA COUNTRY PROGRAM  
EVALUATION: PAPUA NEW GUINEA  
2012-2017**

**FINAL EVALUATION REPORT**

5 December 2016

## COUNTRY MAP PAPUA NEW GUINEA

Figure 1: Map of Papua New Guinea



## EVALUATION TEAM

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November 2016.

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## ABBREVIATIONS

ABG	Autonomous Bougainville Government	IPPF	International Planned Parenthood Federation
ADB	Asian Development Bank	IUD	Intra Uterine Device
ARB	Autonomous Region of Bougainville	JAWP	Joint Annual Work Plan
ASRH	Adolescent Sexual & Reproductive Health	JUNTA	Joint UN Taskforce on AIDS
AWP	Annual Work Plan	LGBT	Lesbian Gay Bisexual & Transgender
CCA	Common Country Assessment	LLG	Local Level Government
CCPD	Common Country Program Document	MCH	Maternal & Child Health
CO	Country Office	MDG	Millennium Development Goal
COAR	Country Office Annual Report	MISP	Minimum Initial Service Package
CPE	Country Program Evaluation	MMR	Maternal Mortality Rate
CYP	Couple Year Protection	MSF	Medicines Sans Frontières
DaO	Delivering as One	MSI	Marie Stopes International
DCD	Division for Community Development	MTDP	Medium Term Development Plan
DFAT	Australian Department of Foreign Affairs & Trade	NACS	National AIDS Commission Secretariat
DHS	Demographic & Health Survey	NCD	National Capital District
DNPM	Department of National Planning and Monitoring	NCW	National Council of Women
DWU	Divine Word University	NDOE	National Department of Education
EMOC	Emergency Obstetric Care	NDOH	National Department of Health
EOC	Essential Obstetric Care	NHATU	National HIV AIDS Training Unit
ERG	Evaluation Reference Group	NPC	National Population Council
FP	Family Planning	NRI	National Research Institute
FSC	Family Support Centre	NSO	National Statistical Office
FSVAC	Family & Sexual Violence Action Committee	NYDA	National Youth Development Authority
FSVU	Family & Sexual Violence Unit	OC	Oral Contraceptive (Pill)
GBV	Gender Based Violence	ODA	Official Development Assistance
GDP	Gross Domestic Product	PCA	Program Coordination & Analysis
GoPNG	Government of PNG	PCW	Provincial Council of Women
HDI	Human Development Index	PEO	Provincial Education Office
HIV	Human Immunodeficiency Virus	PHA	Provincial Health Authority
HQ	Headquarters	PHD	Provincial Health Director
ICPD	International Conference on Population and Development	PHO	Provincial Health Office
INA	Institute of National Affairs		

PLHIV	Person living with HIV
PMC	Population Media Center
PNG	Papua New Guinea
PNGDSP	PNG Development Strategic Plan
RHCS	Reproductive Health Commodity Security
RHTU	Reproductive Health Training Unit
RNI	Rate of Natural Increase
RO	Regional Office
RPNGC	Royal PNG Constabulary
SDG	Sustainable Development Goal
SIS	Strategic Information System
SOP	Standard Operating Procedures
SRH(R)	Sexual & Reproductive Health (& Rights)
STI	Sexually Transmitted Infection
TA	Technical Assistance
TFR	Total Fertility Rate

ToC	Theory of Change
TOR	Terms of Reference
TT	Task Team (UN)
UN	United Nations
UNAIDS	UN Joint Program on AIDS
UNCT	UN Country Team
UNDAF	UN Development Assistance Framework
UNDP	UN Development Program
UNEG	UN Evaluation Group
UNFPA	UN Population Fund
UNICEF	UN Children's Fund
UNRC	UN Resident Coordinator
UNW	UN Women
UoT	University of Technology
UPNG	University of PNG
WHO	World Health Organization
WVI	World Vision International
YWCA	Young Women's Christian Association

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## KEY FACTS TABLE

		Source
Geographical location	Oceania. Group of islands including the eastern half of the island of New Guinea between the Coral Sea and the South Pacific Ocean, east of Indonesia	CIA World Fact Book <sup>1</sup>
Land Area	462,840 sq. km	CIA World Fact Book
Terrain	Diverse with coast line, mountainous and forested areas	CIA World Fact Book
Population	7.3 million (2011)	NSO <sup>2</sup>
Urban Population	25%	UNDP
Population growth rate	3.1%/year	NSO
Median age	21 (2013)	WHO <sup>3</sup>
Population under 19	52% (2011)	NSO
Government	Parliamentary democracy (National Parliament) under a constitutional monarchy; a Commonwealth realm	CIA World Fact Book
Key political events	Attained independence in 1975 (from the Australian-administered UN trusteeship)	CIA World Fact Book
Gross Domestic Product	US\$16.19 billion (2014)	World Bank
GDP growth rate	8.5% (2014)	World Bank
GDP/capita	US\$ 2,100 (2014)	World Bank
Main industries	The economy has a small formal sector, focused mainly on the export of natural resources (copper, gold and oil), and an informal sector, employing the majority of the population. Agriculture provides a subsistence livelihood for 85% of the people.	
Population dependent on agriculture	75%	World Bank
Population living on < \$1/ day	40%	UNDP
Poverty rate	37.5 %	UNDP
Unemployment rate	2.3% (2012)	ILO <sup>4</sup>
Youth Unemployment rate	5.1% (2012)	ILO
Official development assistance	US\$ 577.3 m (2014)	World Bank

<sup>1</sup> CIA World Fact Book, <https://www.cia.gov/library/publications/the-world-factbook/geos/pp.html>

<sup>2</sup> NSO, PNG Population and Housing Census, 2011

<sup>3</sup> <http://apps.who.int/gho/data/node.country.country>

<sup>4</sup> [http://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/---ilo-suva/documents/publication/wcms\\_366539.pdf](http://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/---ilo-suva/documents/publication/wcms_366539.pdf)



		Source
Official development assistance	4.5% of GNI (2014)	UNDP <sup>5</sup>
Human Development Index	158/187 countries (2015)	UNDP
Life Expectancy at birth	M 61yrs - F 65 yrs. (2015)	World Bank
Literacy Rate	64.2% average (M 65.6% - F 62.8%)	UNDP
Gender development index	NA	UNDP
Gender Inequality Index	0.611	UNDP
Probability of dying of maternal causes	10% (age 15-49) (2013)	WHO
Total expenditure on health/capita	US\$ 109 (2014)	WHO
Total expenditure on health/GDP	4.3% (2014)	WHO
Total Fertility Rate	3.8 births/woman (2014)	World Bank
Adolescent Fertility Rate	55.3/ 1,000 women 15-19 (2014)	World Bank
Contraceptive Prevalence Rate	32.4% (2007)	WHO
Unmet need for FP	27.4% (2007)	WHO
Births attended by skilled staff	40% (2006)	DHS <sup>6</sup>
Birth registration coverage	NA	WHO
Maternal Mortality Ratio	733/100,000 live births (2006) 470 (1990)	DHS
Under 5 mortality rate	57.3/1,000 live births (2015)	World Bank
Neonatal Mortality Rate	24/1,000 live births (2013)	WHO
HIV prevalence (15-49)	0.7% (2015)	World Bank

<sup>5</sup> UNDP, Human Development Index Report PNG, 2015

<sup>6</sup> Demographic and Health Survey, 2006

## EXECUTIVE SUMMARY

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### PURPOSE AND AUDIENCE OF THE COUNTRY PROGRAM EVALUATION

The purpose of the Country Program Evaluation (CPE) is twofold: 1) a learning tool which will serve as a major input for the planning process of the next Country Program cycle; and 2) an accountability tool to measure the delivery of results during the current, 5<sup>th</sup> Country Program (2012-2017). The audience for the evaluation consists of UNFPA decision makers at country, regional and global level. This evaluation was commissioned by UNFPA Papua New Guinea and conducted in line with the Evaluation Policy of UNFPA

### OBJECTIVES OF THE EVALUATION AND A DESCRIPTION OF THE COUNTRY PROGRAM

The CPE determines how UNFPA contributed to national development efforts, including its alignment with the Government of PNG's priorities and strategies and how UNFPA's work is shaping the development agenda. The evaluation assesses the efficiency, effectiveness, relevance, and sustainability of the initiatives that have been supported by UNFPA during the program cycle. It also assesses UNFPA's contribution to the United Nations Country Team (UNCT) coordination mechanism and the added value UNFPA brings to the country.

Papua New Guinea's challenges for sustainable development include rapid population increase, with 52% of the population younger than 19. Recent economic growth based in extractive industries has slowed due to the global economic crisis and reduced fuel prices, resulting in budget cuts to the health sector. Maternal mortality in PNG is high, as are fertility rates for women and adolescent girls. Acceptance of modern family planning is low, partly due to cultural and religious opposition. The HIV epidemic is concentrated among female and transgender sex workers, and men who have sex with men, but the largest sub-group of PLHIV are women of reproductive age. Challenges for the health sector include insufficient human resources and health infrastructure, decentralized planning and management, including supply chain logistics. There are no youth friendly health services in PNG. Gender based violence is a big social problem, directly and indirectly affecting sexual and reproductive health.

The UNFPA country program 2012-2017 is part of the "One UN" Development Assistance Framework (UNDAF) and action plan. UNFPA participates in 5 joint UN task teams, organized around UNDAF results. UNFPA reports bi-annually to the 5 tasks teams, and jointly through annual UNDAF progress reports. The UNFPA Country Program 2012-2015 (extended to 2017) is a joint document with UNDP and UNICEF, but contains specific results for UNFPA: 1) population and development; 2) sexual and reproductive health (including HIV and adolescents); and 3) gender. UNFPA works at national level and in four priority provinces: Autonomous Region of Bougainville (ARB), Central Province; Enga Province and Morobe Province. The total core budget for the country program to date was over US\$ 9 million

## EVALUATION METHODOLOGY

The evaluation took place from August - October 2016, with a three-week field phase in September. The methodology is in accordance with UNFPA guidance, and includes mixed methods with triangulation and validation of the findings. An evaluation matrix, based on the evaluation questions and agreed by the Evaluation Reference Group, provides the framework for the fact-finding and analysis. Limitations to the methodology include a problematic result framework for the UNFPA country program, absence of narrative progress reports, and sampling of field sites and key informants. However, a validation workshop with stakeholders confirmed validity and completeness of the field findings and documentation review.

## MAIN CONCLUSIONS

Conclusion #1: UNFPA has contributed to development of supportive policies for population and SRH, but provincial authorities need and demand support to operationalize these supportive policies and strengthen systems, strategies and services for SRH to improve health outcomes.

Conclusion #2: Adolescents are a priority and an opportunity for increasing sexual and reproductive health, and sustainable population growth in PNG, yet the PNG country program does not have a specific result area for ARSH.

Conclusion #3: The UNFPA PNG program does not have an “evaluation culture”: most interventions are not based on formative research<sup>7</sup> (needs assessment or problem analysis), and their objectives are poorly articulated or tracked. This threatens the relevance and effectiveness of the whole program.

Conclusion #4: Whilst the reduction in core resources provided an opportunity for UNFPA PNG to consolidate the country program and increase synergy & cost-effectiveness, resource mobilization resulted in multiple, unrelated interventions of limited scale and reduced synergy within the program.

Conclusion #5: UNFPA adds value to the one UN response in PNG, but UNFPA’s CPE guidance is not suitable to evaluate UNFPA’s contribution to joint UN programming

## RECOMMENDATIONS

Recommendation #1: Ensure that the design of the country program and individual interventions are based on formative research or international good practice; develop and use an M&E system as per corporate guidance, and undertake operational research to document lessons and inform policy dialogue. Operational implications are:

1. UNFPA should undertake formative research to ensure relevance of the next country program, and not rely on the UN Common Country Assessment, because that does not provide the level of detail needed.

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<sup>7</sup> Formative research is research conducted before a program or activity is designed and implemented, to help identify answers to these questions. This type of research is also referred to as needs assessment.

2. The next country program must have an M&E system as per UNFPA corporate guidance.
3. The UNFPA country team should monitor and evaluate progress towards UNFPA country program objectives.
4. The next country program should include operational research<sup>8</sup>, to generate strategic information and evidence for policy development.

Recommendation #2: Increase the strategic focus of the 6th country program through prioritizing of strategies, interventions, partner organizations, and priority provinces. Increase the scope and scale of effective interventions, and discontinue interventions without established relevance or effectiveness. Operational implications are:

1. In developing the 6th country program, UNFPA should increase focus of the design by reducing the total number of support activities and interventions, and considering discontinuation of those without evidence of effectiveness or relevance. Alternatively UNFPA must include research to establish such evidence.
  - Examples of support activities without evidence of effectiveness or relevance are peace-building work in Bougainville; all service delivery, and gender based violence responses in non-health sectors.
  - Examples of support activities with established relevance and effectiveness are population & development; family planning work; adolescent sexual and reproductive health, and health sector response to GBV)
2. To increase impact of the program, UNFPA should continue and expand support activities with established relevance as well as effectiveness.
3. UNFPA should reduce and prioritize the number of counterpart ministries and sectors for the 6th country program, to increase efficiency and impact, prioritizing the health and planning departments.
4. In the 6th country program, UNFPA needs to increase targeting of technical assistance to decentralized governments (especially health departments) and focus more on priority provinces.

Recommendation #3: Increase cost-effectiveness, sustainability and impact of the 6th country program through review and revision of capacity building approaches, and support for training logistics. Operational implications are:

1. UNFPA should commission a review and revision of the capacity building approaches, including an evaluation of effectiveness and cost-effectiveness of training small groups of people, versus alternative approaches.
2. UNFPA should evaluate the cost-effectiveness of direct management of training logistics and consider alternative strategies.

Recommendation #4: UNFPA corporate guidance for Country Program Evaluations needs to be reviewed and revised for UNFPA country programs that are implemented in 'Delivering as One' countries, so that the tools and methods enable assessment of effectiveness and relative contribution of UNFPA to joint UN programs, and accountability for results.

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<sup>8</sup> Operational research provides decision-makers with information to enable them to improve the performance of their programs. Operational research helps to identify solutions to problems that limit program quality, efficiency and effectiveness, or to determine which alternative service delivery strategy would yield the best outcomes ([http://www.who.int/hiv/pub/operational/or\\_guide\\_gf.pdf](http://www.who.int/hiv/pub/operational/or_guide_gf.pdf))

## 1. INTRODUCTION

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This chapter reflects the terms of reference for the UNFPA PNG country program evaluation<sup>9</sup>.

### 1.1 PURPOSE AND OBJECTIVES OF THE COUNTRY PROGRAM EVALUATION

The purpose of the Country Program Evaluation (CPE) is twofold: 1) a learning tool which will serve as a major input for the planning process of the next Country Program cycle; and 2) an accountability tool to measure the delivery of results during the current, 5<sup>th</sup> Country Program (2012-2017).

The CPE determines how UNFPA contributed to national development efforts, including its alignment with the Government of PNG's priorities and strategies and how UNFPA's work is shaping the development agenda. The evaluation assesses the efficiency, effectiveness, relevance, and sustainability of the initiatives that have been supported by UNFPA during the program cycle. It also assesses UNFPA's contribution to the United Nations Country Team (UNCT) coordination mechanism and the added value UNFPA brings to the country.

The exercise corresponds to a CPE commissioned by the country office, and this evaluation is conducted in line with the UNFPA Evaluation Policy.

#### *Users of the evaluation*

As the results of the CPE will inform the development process of the 6th Country Program cycle in PNG, the main users of the evaluation results will be decision-makers of UNFPA at country office, regional and global level, and the organization's Executive Board. Moreover, counterparts in the Government of PNG, UN partners and other development partners may be interested to review the evaluation findings and recommendations.

### 1.2 SCOPE OF THE COUNTRY PROGRAM EVALUATION<sup>10</sup>

The time period for the CPE was the 5<sup>th</sup> UNFPA PNG country program from 2012 to 2015, including the extension 2016-2017. The PNG Common Country Project Document and UNFPA results framework guided the assessment of effectiveness and results achieved at output level.

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<sup>9</sup> See Annex 2: Terms of Reference

<sup>10</sup> See also Annex 2: Terms of Reference

Geographically, the CPE covered both national and sub-national levels. As UNFPA PNG focuses its program efforts on four focal provinces (Autonomous Region of Bougainville, Central, Enga, and Morobe) - the sub-national focus of the evaluation was on these provinces. All UNFPA's program components (Sexual and Reproductive Health, Youth and Adolescents, Gender, and Population) were evaluated.

The UNFPA PNG's mode of engagement was also to be evaluated. UNFPA has categorized PNG as an "orange country"; therefore the CPE also addressed the UNFPA PNG country office's modes of engagement (advocacy, capacity development and knowledge management) and what were the challenges associated with the individual modes of engagement as well as their combination in the country program at national and sub-national levels.

Finally, the evaluation took into account the modality of delivery of development support, namely, UN Delivering as One, and Gender Equality and Empowerment of Women (GEEW) as a specific and cross-cutting components.

### 1.3 METHODOLOGY AND PROCESS

The Country Program Evaluation is carried out in accordance with the UNFPA Evaluation Policy, and the UNFPA CPE handbook. The evaluation also followed UNEG Norms and Standards for Evaluation in the UN system, abiding by UNEG Ethical Guidelines and Code of Conduct, UNEG guidance for including gender, equity and human rights, and any other relevant ethical codes. The CPE selected gender responsive evaluation questions, methods, tools and data analysis techniques where appropriate, and the CPE team included a gender & development expert.

#### *Methods for data collection*

The CPE methodology is presented in the *evaluation matrix* as agreed in the design report and annexed to this report<sup>11</sup>. For each of the ten evaluation questions presented above, the evaluation matrix proposes assumptions to be tested, indicators and sources of information to do so, so that evaluation findings are supported by evidence. The evaluation matrix is based on a comprehensive review of documentation, including monitoring data of program components and annual and other reports of the program, its components and initiatives. The evaluation matrix includes indicators for GEEW. The evaluation matrix was developed during the design phase of the CPE.

The CPE used a *mixed method approach*, using qualitative as well as quantitative information on the program's achievements and challenges. Data were collected through multiple approaches including 1) documentation review; 2) semi-structured key informant interviews; 3) group discussions, and 4) observation during field visits. Data collection took place during the 3-week field phase of the evaluation. The data collected through multiple methods were *triangulated* and analyzed by the evaluation team, to reduce the possible data limitations and limit reliance on single source data so to enhance the validity of the findings. Quantitative data on programs and services was disaggregated for sex and age where possible and appropriate.

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<sup>11</sup> Annex 1

The evaluation utilized a *theory-based approach*: the CPE evaluation team was expected to reconstruct the intervention logic behind the program interventions, because the UNFPA 5<sup>th</sup> Country Program in PNG does not have an explicit Theory of Change. The Theory of Change was tested during the field and data collection phase. Details of the Theory of Change and interventions logic are provided in chapter 3.1, under ‘effectiveness’ (page 31).

The evaluation was *forward looking*. The focus was on learning lessons for the design of the next country program.

The evaluation used *appreciative enquiry* approaches, focusing on identifying what worked well, and what positive lessons can be learned from what did not work. Enquiry aimed to appreciate and document significant change towards implicit or explicit goals, as well as any unintended consequences of the program.

*Participation* in the evaluation design and conduct was broad. An Evaluation Reference Group with inclusion of UNFPA country staff, government counterparts and UN partners guided the evaluation and approved the design report. Based on a stakeholder mapping, the evaluation team identified key informants to visit and/or interview. The evaluation team also used group exercises where possible and appropriate, for example with the UNFPA country office team, the validation workshop and during focus group discussion.

*Evaluation criteria* of the CPE included relevance, effectiveness, efficiency and sustainability of the initiatives that have been supported by UNFPA during the program cycle. It also assessed UNFPA’s contribution to the United Nations Country Team (UNCT) coordination mechanism and the added value UNFPA brings to the country. For each evaluation criterion, one or more evaluation questions were formulated in the TOR. The evaluation team proposed one additional evaluation question for effectiveness: ‘To what extent has the sexual and reproductive health interventions achieved outcomes in term of contraception, skilled delivery, and emergency obstetric care services?’

Table 2: Evaluation Criteria

Evaluation Criteria
1. <i>Relevance</i> of the UNFPA Country Program in relation to the issues it was designed to address
2. <i>Effectiveness</i> of UNFPA implementation and performance, i.e. progress towards agreed country program outcomes
3. <i>Efficiency</i> of resources used to implement the Country Program:
4. <i>Sustainability</i> of the results achieved and strategies used by UNFPA
5. <i>Contribution to the UNCT Coordination</i> mechanism in PNG
6. <i>Added value of UNFPA</i> to development activities in PNG

*Sampling of field sites to visit and informants to interview* was purposive, to ensure that data collection was representative as well as efficient. Sampling was agreed with the Evaluation Reference Group, and selection criteria included: type of stakeholder (counterpart/ implementer/ beneficiary), location, and programmatic involvement. Provinces visited were the National Capital District (NCD), the Autonomous Region of Bougainville (ARB) and Morobe, where most activities are implemented, while documentation review and key informant

interviews covered Enga and Central Provinces. Key informants interviewed are presented in Annex 2A.

*Table 3: informants<sup>12</sup>*

informants	# informants
Government (national)	11
Government (provincial)	16
Implementing partners/NGOs	27
Intervention beneficiaries	8
UN agencies & donors (ex UNFPA)	11
UNFPA	8
Female	45
Male	30
National actors	37
Local actors	38
<b>Total</b>	<b>75<sup>13</sup></b>

#### *Limitations encountered and reliability of data*

The evaluation acknowledges several limitations of the evaluation methods, mainly affecting the *efficiency* of data collection. The *completeness and correctness* of evidence however did not suffer and was confirmed in the data validation workshop.

Limitations anticipated in the design report included a) time constraints (total of three weeks allocated for the field phase, two weeks for provincial visits); b) high turnover of the staff of the governmental institutions and the NGOs, and movement of beneficiaries; and c) geographic location (e.g. some districts cannot be reached for security reasons or due to limited transport options); and, d) budget constraints to travel. These constraints were mitigated by the use of secondary data (reports, publications, national plans, regional strategy plans, etc.); through key informant interviews and focus group discussions; and purposive sampling of sites to visit and key informants to interview.

Second, the evaluation team found it hard to access documentation of UNFPA progress, e.g. a single country program narrative progress report. Progress information, often partial and/or coded, is included in a multitude of different reports, including 1) 10 semi-annual reports per year to 5 joint UN task teams<sup>14</sup>; 2) annual reports to UNFPA HQ on corporate indicators; 3) UNFPA country office expenditure reports with (Atlas) codes for partners and activities; and 4) progress reports to donors for additional activities (beyond the remit of the joint UN work plan). Information on specific activities (e.g. training reports, research reports, etc.) was also hard to access due to UNFPA staff changes since 2012, and lack of systematized knowledge/information management systems. To mitigate this, the team developed a table to collate all available progress and output data, and validated this at a workshop (See Annex 5)

<sup>12</sup> Excluding participants of the data validation workshop who were not interviewed separately.

<sup>13</sup> Overlap exists between categories

<sup>14</sup> See chapter 3.1 for explanation



Third, UNFPA's work is designed, implemented and monitored as part of the Joint UN Development Assistance Framework (UNDAF, see chapter 3.1), with *joint* UN outcomes, outputs and indicators; joint activities and joint progress reports. As mentioned above there are no UNFPA specific narrative progress reports, as all UN agencies monitor and report support jointly, without identifiers to individual UN agencies. As a consequence, the UNFPA result framework is not used for reporting, and UNFPA contribution and attribution to joint UN outcomes is hard to measure. Besides, a recent evaluation of the UNDAF found problems with the joint UN result framework<sup>15</sup>. This limitation was mitigated by including UN joint progress reports in the analysis, and construction and validation of a specific UNFPA activities and outputs overview (see annex 5)

Fourth, access to country office staff was limited due to competing priorities for the UNFPA country team<sup>16</sup> and the departure of the UNFPA country representative during the CPE. As a result, UNFPA technical officers could not fully participate in the team workshop, field visits and validation workshop; finance & admin staff were busy and not interviewed. UNFPA program staff did not accompany the evaluation team to the field, which increased independence but opportunities to provide context were missed. Limited access to staff was compensated by additional interviews with stakeholders and documentation review

Finally, some bias exists due to sampling of field sites, project visits and informants. The team negotiated the tradeoffs between limited time availability, a broad range of partnerships and activities, and the logistics of travel and scheduling interviews. This was done in coordination with the ERG. Despite this bias, the team was able to collect and triangulate data, and validate this information at the validation workshop.

The CPE further ensured reliability of data collection by 1) triangulating all data collected; 2) using of qualitative and quantitative data sources? (See above); 3) sensitivity to issues of discrimination and other ethical considerations (according to UNEG guidance), and 4) gender disaggregation of data where possible and appropriate.

### *Evaluation Process*

*1. Preparatory Phase:* Outputs included 1) constitution of the Evaluation Reference Group (ERG), 2) selection and hiring of evaluation team; 3) collection of relevant documents and 4) a stakeholder mapping

*2. Design Phase (August 2016):* Output is the design report. Evaluation team undertook 1) preliminary desk review of all available documents; 2) tentative sampling of key informants and sites to visit; 3) analysis of the intervention logic of the program; 4) finalization of the list of evaluation questions and evaluation matrix

*3. Field Phase (September 2016):* The evaluation team undertook in-country mission of 3 weeks to collect and analyze the data required in order to answer the evaluation questions, and to get a grounded understanding of the issues at both national and sub-national level. The field phase

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<sup>15</sup> LuAnn et al, 2016, UNDAF Evaluation report

<sup>16</sup> Enumerator training for DHS 2016 coincided with the country program evaluation

ended with an internal data analysis meeting, validation workshop to validate preliminary findings, and debrief to UNFPA/UNDP to test tentative conclusions.

*4. Reporting Phase (October 2016):* The evaluation team leader drafted the evaluation report, taking into account comments made at the validation meeting/debrief. Comments consolidated by the UNFPA Evaluation Manager helped develop the final draft evaluation report. Additional comments from the UNFPA regional office guided finalization of the report.

*5. Dissemination, management response and follow-up Phase:* This phase is the responsibility of the UNFPA Evaluation Manager. The final draft evaluation report will form the basis for an in-country dissemination meeting/presentation, which will be attended by the CO as well as all the key program stakeholders. During this phase, the CO will prepare a 'management response', to be included in the final evaluation report, also taking into account comments made by the participants. The final Evaluation Report, along with the Management Response, will be published in the UNFPA evaluation database. The evaluation report will also be made available to the UNFPA Executive Board and will be widely distributed within and outside the organization.

## 2. COUNTRY CONTEXT

### 2.1 DEVELOPMENT CHALLENGES AND NATIONAL STRATEGIES

Papua New Guinea (PNG) faces a range of complex development challenges. As noted in the Table of Facts, PNG is very diverse geographically and culturally, with over 800 ethnic groups and languages spread over 600 islands in Oceania. Papua New Guinea's social indicators lie below those of other countries with similar income per capita levels. The formal economy consists of export of natural resources such as gold, copper and oil. An estimated 40 per cent of the population lives on less than US\$ 1 per day and that 75 per cent of households depend on subsistence agriculture. In 2012 only 7 per cent of the population had access to the electric grid and reticulated water<sup>17</sup>. The Human Development Index (HDI) value for 2014 placed PNG in the low human development category and positioning it at 158 out of 188 countries and territories<sup>18</sup>. An important social development challenge for PNG is the relatively high level of crime and violence (including domestic violence), which has a long-term social impact. High crime rates also contribute to high security overheads for development partners, thus constraining mobility and negatively impacting development interventions.

In recent years the Government of PNG (GoPNG) developed several social and economic development strategies in support of the Millennium Development Goals (MDGs). These plans include the 1) PNG Vision 2050; 2) PNG Development Strategic Plan (PNGDSP) 2010 – 2030; 3) Medium Term Development Plans (MTDP) 2011-2015, extended to 2016-2017 and 4) a National Strategy for Responsible and Sustainable Development (2014). The purpose of the MTDP is to implement the PNGDSP 2010-2030 to achieve the goal of the PNG Vision 2050.

PNG has experienced significant economic development changes within the last five years. The country recently graduated from a low income to a lower-middle income country status, because of financial resources generated from the extractive sector. With export of liquefied natural gas in 2014, GDP was expected to rise by 20 to 25%<sup>19</sup>. The Government of PNG (GoPNG) increased the budget by 87% for the sub-national levels of government, and by 38% for health, education, infrastructure and law and order. However, the extractive-based form of development has not been inclusive, and many Papua New Guineans did not benefit<sup>20</sup>. Besides, by end 2015, GoPNG faced a fiscal crisis, due to lower commodity prices in the international markets, and decreasing economic activity. Since, several public budget cuts have been made, placing a strain on the ability of the Government to adequately provide social services such as health and education.

PNG has a high level of decentralization with 22 provinces, 89 districts, 313 Local Level Governments (LLGs) and 6,131 Wards. In the earlier period of the country program, the country also faced periods of political instability including the 2011-2012 constitutional crisis.

<sup>17</sup> UNFPA (2014). Population and Development Profiles: Pacific Island Countries.

<sup>18</sup> UNDP (2015). PNG: Briefing note for countries on the 2015 Human Development Report

<sup>19</sup> World Bank (2013). Papua New Guinea Economic Briefing: From the last days of the boom to lasting improvements in living standards.

<sup>20</sup> United Nations Development Program (2015). National Human Development Report: Papua New Guinea





## 2.1.1 SITUATION REGARDING ICPD RELEVANT DEVELOPMENT GOALS

### *PNG strategies on sexual and reproductive health and gender*

National policies and strategies relevant to sexual and reproductive health and population include the *National Population Policy 2015-2020* based on lessons from the earlier policy, namely that decentralized implementation did not happen as planned, and that the demographic transition has stalled. The *National Health Plan 2001–2010* stated that health care responsibilities at the national level include “securing adequate levels of medicines, contraceptives and other supplies”. The *National Health Plan 2011–2020* outlines 8 key result areas to improve service delivery and health outcomes. One result is to “improve maternal health” through 4 objectives: 1) increasing family planning coverage; 2) increasing the capacity of the health sector to provide safe and supervised deliveries; 3) improving access to emergency obstetric care, and 4) improving sexual and reproductive health for adolescents. Further policy guidance comes from a variety of health sector policies, mostly developed since 2012, including the Youth Health Policy, Gender and Health Policy, Family Planning Policy and the National AIDS Strategy.

The government reported mixed, but overall limited progress towards the Millennium Development Goals (MDGs). The MDGs relevant to sexual and reproductive health and population are 3, 4, 5 and 6. Achievements are reported in halting and reversing HIV and malaria as well as increased enrolments in primary and secondary education. Constraints include lack of strategic information, weak implementation frameworks and limited monitoring of targets<sup>21</sup>.

*Table 4: PNG progress towards ICPD relevant MDGs*

MDG		Progress
 3	Target 3.A. Eliminate gender disparity in primary and secondary education, preferably by 2015, and in all levels of education no later than 2015.	Off track
 4	Target 4.A. Reduce by two thirds between 1990 and 2015, the under-five mortality rate	Off track
 5	Target 5.A. Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	Off track
	Target 5.B. Achieve by 2015 universal access to reproductive health	Off track
 6	Target 6.A. Have halted by 2015 and begun to reverse the spread of HIV/AIDS	Off track

A challenge to basic service delivery is the diverse and dispersed population, and high logistical costs and supply chain management issues. Many parts of the country are inaccessible by road.

<sup>21</sup> Lund A et al, 2016, UNDAF Evaluation PNG

The trend towards decentralization is challenged by inefficiencies in the public service, due to weak capacity among both line government agencies and the sub-national service providers<sup>22</sup>. In the health sector, challenges include closure of health facilities<sup>23</sup>, vacant positions of health workers in rural areas, insufficient numbers of health workers per capita and an ageing health workforce<sup>24</sup>.

### *Population and Development*

PNG had a population of 7.3 million people as of 2011<sup>25</sup>. PNG has a “youth bulge” with 52% of its 7.3 million inhabitants being under the age of 19, one of the highest proportions in the Pacific. The population is estimated to reach 13 million people in 2032 at its current annual population growth rate of 3.1%. The rapid population growth is putting strain on service delivery and infrastructure, for example classrooms and schools. About 30% of school aged children, or 600,000 children, do not go to school at all, and many drop out of basic primary education. Two-fifths of health/sub-health centers and rural health posts had no electricity or essential medical equipment<sup>26</sup>

Population data is available in PNG, but under-analyzed and under-utilized by policy makers. The National Statistical Office (NSO) conducted the National Census in 2011, but data from the census was not published and released to the public until January 2014. Many staff at NSO were initially overwhelmed by the sheer volume of data collected and were not able to sort through, collate or analyze the data. With the support of UNFPA, data from survey results were finally tabulated and published.

### *Sexual and reproductive Health*

PNG has one of the highest maternal mortality rates (MMR) in the world at 733 per 100,000 live births<sup>27</sup>. This means that around 1,300 women die as a result of pregnancy-related problems every year. For women in urban settings the risk of dying while giving birth is lower than for those women living in rural areas. Unsupervised deliveries (without a skilled birth attendant) in rural settings are common (only 40% of births are supervised) and a mother’s risk of dying in childbirth is four to eight times higher in rural as compared to urban areas. Less than 60% of pregnant mothers access antenatal services<sup>28</sup>. Most rural health facilities are in dire need of repair and provision of supplies. Furthermore, health staff commonly struggle and lack the skills to provide effective treatment and services.

The total fertility rate (TFR) in PNG has remained high, with women in urban areas having a lower TFR than women in rural areas (3.6 and 4.4 respectively). On average, women have 4 children. The unmet need for family planning is 30% among married women, whilst

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<sup>22</sup> UNDP, 2015, National Human Development Report: Papua New Guinea

<sup>23</sup> NHIS, 2012

<sup>24</sup> The World Bank (WB) 2011, PNG Health Workforce Crisis: A Call to Action, quoted in 2014, UNFPA, Family Planning and Reproductive Health Commodity Needs Assessment.

<sup>25</sup> NSO, 2011, National Population and Housing Census

<sup>26</sup> UNFPA, 2014. Population and Development Profiles: Pacific Island Countries.

<sup>27</sup> Demographic and Health Survey, 2006

<sup>28</sup> Demographic and Health Survey, 2006

contraceptive prevalence (using modern methods) is only 32%<sup>29</sup>. The National Health Plan 2011-2020 aspires to an ambitious contraceptive prevalence of 65% by 2020, through providing contraception at every health facility; advocacy for spacing of children; and engaging village health workers and community-based distribution systems. Barriers to family planning service uptake at the supply side and the demand side are numerous<sup>30</sup>: on the supply side these include limited choice of methods, especially in Catholic health services, poor supply chain management<sup>31</sup>, and limited integration of family planning in other SRH services. On the demand side, one in five women have no knowledge of modern contraceptives and 44% have no intention to use it<sup>32</sup>, limited demand by men<sup>33</sup>, and limited demand creation initiatives. Under the Criminal Code, abortion is generally illegal but is permitted to save the life of the pregnant woman<sup>34</sup>.

The prevalence rate of HIV for PNG is the highest in the Pacific at 0.9%. Female and transgender sex workers and their sex partners are key populations most vulnerable for HIV infection (with men who have sex with men). HIV testing, counseling and management is poorly integrated into sexual and reproductive health services.

#### *Adolescent sexual and reproductive health*

As mentioned before, 52% of Papua New Guineans are younger than 19. Young people start to become sexually active, develop partnerships and start families. They also bring the opportunity for societal change and human capital.

According to the 2006 DHS, the median age at first sexual intercourse among women aged 20–49 was 18.7 years and 19.5 for men. Four per cent of youth aged 15–24 have had sexual intercourse before age 15. Out-of-school youth are more likely to report sexual experience: over two thirds of unmarried males and females aged 15–24 have had sex, with 16 as the median age of first sex. More than 50% of male and 20% of female out-of-school youth reported ever having had anal sex. About 12% of young men reported having had sex with another man<sup>35</sup>.

The 2006 DHS found that the median age at first marriage for ever-married men was 22.2 years in 2006. The overall prevalence of polygynous unions among young women was 18.3% more prevalent among urban women and those with less educational achievement<sup>36</sup>. Besides, sexual violence including rape is common in PNG: sexually transmitted infections (STI) including HIV are common among adolescents; for example the majority (>70%) of HIV infected pregnant women diagnosed at the Port Moresby General Hospital are aged 15–24<sup>37</sup>.

<sup>29</sup> Demographic and Health Survey, 2006

<sup>30</sup> 2014, UNFPA, Family Planning and Reproductive Health Commodity Needs Assessment

<sup>31</sup> DFAT, 2013

<sup>32</sup> NSO, 2009, quoted in 2014, UNFPA, FP and RCH Needs Assessment

<sup>33</sup> NSO, 2009, p66

<sup>34</sup> WHO-WPRO, 2012, Adolescent Health in PNG

<sup>35</sup> WHO-WPRO, 2012, Adolescent Health in PNG

<sup>36</sup> WHO-WPRO, 2012, Adolescent Health in PNG

<sup>37</sup> WHO-WPRO, 2012, Adolescent Health in PNG

In 2006, the median age at first birth for women was 20.5 years; almost one in six women gave birth to their first child before reaching the age of 18. The age-specific fertility rate (ASFR) of adolescents aged 15–19 was 65 per 1,000. In urban areas fertility peaks later (25-29) than in rural areas (20-24)<sup>38</sup>.

Contraceptive use among adolescents is low. Although knowledge of contraception is generally high, only 2.6 % of unmarried female adolescents aged 15–19 reported using a modern method (condoms, pills, injection), and only 12.1% among married women that age group<sup>39</sup>.

### *Gender*

Gender equality is a significant challenge in PNG, and systemic violations of women’s rights exist throughout the country. In 2014, Papua New Guinea ranked 140 out of 155 countries of the Gender Inequality Index<sup>40</sup>. Women and girls have substantially less access to health care and education services than males. Furthermore, women are vastly under represented at all levels of government (only 3 out of 111 Parliamentarians are women), limiting their power to influence public policy and voice issues. Women’s participation in the public sector has improved. There are four women judges, one magistrate, four secretaries of departments, one vice chancellor, two heads of diplomatic missions and one secretary-general of a regional organization. Up to 45 women councilors have been elected, two mayors and one acting provincial administrator in the lower tiers of government.

In rural and urban areas, Papua New Guinean men and women commonly hold onto their traditional cultural practices, where tribal discipline and power is given to men to have authority over their clan and family members. Men make most of the decisions in the family and control most of the resources, and women are expected to conform to various societal rules and norms, often having their basic rights denied. Nevertheless, women’s labor is highly valued and have been known in certain areas to be included as part of compensation payments to resolve disputes. Women are not allowed to control their own sexuality. The conflict between her clan obligations and individual human rights leave her vulnerable to sexual and gender-based violence, which has become endemic in PNG society. Violence against women and gender-based violence is unacceptably high, with an estimated two out of three women having personally experienced violence<sup>41</sup>.

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<sup>38</sup> Demographic and Health Survey, 2006

<sup>39</sup> WHO-WPRO, 2012, Adolescent Health in PNG

<sup>40</sup> UNDP (2014). National Human Development Report: Papua New Guinea

<sup>41</sup> UNFPA (2014). Population and Development Profiles: Pacific Island Countries. Pacific Sub-Regional Office

## 2.1.2 CONTEXT IN THE FOUR UNFPA PRIORITY PROVINCES

The 5<sup>th</sup> UNFPA country program identifies four priority provinces to support local government and their partners. These four provinces were selected in the previous country program; selection criteria mentioned in the CPE TOR are high population growth, high GBV rates, low contraceptive use and limited family planning service availability<sup>42</sup>.

### *Autonomous Region of Bougainville (ARB)*

Bougainville faces the aftermath of violence after the civil war during which thousands of men and women lost their lives. In 2001, the Bougainville Peace Agreement ended the civil conflict and the province presently prepares for a referendum about independence. The UN system supports the AGB with political, social and economic development.

ARB is a traditionally high fertility province, but fertility dropped to marginally higher than the national average of 4.2<sup>43</sup>. A recent family health study found that contraceptive use is very uncommon due to poor access and cultural reasons: one in five husbands had forbidden contraceptive use. One in four women and one in three men said they had sex for the first time before the age of 18 years, and many women were raped the first time they had sex<sup>44</sup>.

Mental health is a significant concern in Bougainville; it affects women and men in different ways, and can be driven by experiences of trauma. A recent study suggests that a quarter of men and one in seven women probably have Post Traumatic Stress Disorder. One in four men and one in three women had experience depressive symptoms, and substance abuse is common, including binge drinking and drug use by men. The study also indicated that violence in communities and families is very common, due to factors including generalized post-traumatic stress and deeply ingrained gender inequality.

### *Central Province*

Central Province is on the southern coast of the country, next to Port Moresby, and the provincial government is located in NCD. The population is 237,016 people. Many people commute to earn non-agricultural wage incomes in and around Port Moresby. A road runs along the length of the province, and areas around Port Moresby are also well served by roads.

Mortality in Central Province has on average always been, and still is significantly lower than the national average, probably partly due to relatively easy access to the health and other facilities in the NCD. Yet there is extreme variance within the province, with the mortality in Goilala District of Central Province is probably amongst the highest in PNG. Fertility is higher than the national average TFR. There is very significant temporary movement between Central Province and the NCD. <sup>45</sup>

<sup>42</sup> Selection criteria not discussed in the Country Program Document

<sup>43</sup> NSO, 2016, Fertility Monograph (draft)

<sup>44</sup> Jukes R. et al, 2013, Family Health and Safety Study, Autonomous Region of Bougainville, summary report

<sup>45</sup> NSO, 2016, Fertility Monograph (draft)



### *Enga Province*

Enga is one of the seven Highlands Provinces in Papua New Guinea, and used to be part of the Western Highlands Province. The population is 432,045 people. Mortality of Enga continues to be higher than the national average. Fertility in Enga has been consistently lower than the national average, as is population growth<sup>46</sup>. Enga is the only province that has only one major linguistic and ethnic group. The province is located in mountainous terrain.

### *Morobe*

Morobe Province is located on the northern coast. With a population of 674,810 it is the most populous province of PNG. The capital Lae is the second urban sector in PNG and has a large port. Despite the presence of the Highlands Highway, large parts of the rural sector are not easily accessible. Levels of mortality and fertility are close to the national average. Recently Morobe experienced significant in-migration and out-migration but lower than in-migration<sup>47</sup>.

## **2.2 THE ROLE OF EXTERNAL ASSISTANCE IN PNG**

PNG receives international development assistance but the GoPNG is actively seeking to transition to trade rather than aid. In 2013, the World Bank reported net flows to PNG of slightly over US\$ 910m per annum, then close to 10 per cent of GDP<sup>48</sup>. The four largest sectors (in terms of ODA plus GoPNG 'spend') were education, health and HIV/AIDS, transport infrastructure, and law and justice. As of 2015, ODA had decreased in absolute terms, and even more so as a percentage of GDP, because annual GDP has increased (see table 5). This trend is predicted to continue.

Australia is PNG's largest partner, providing annual assistance close to A\$ 500m with a whole-of-government program supporting public financial management and improved national statistics. The Asian Development Bank (ADB) program focuses on infrastructure (transport, power, water & sanitation), state enterprise reform, trade, microfinance, and health. Other bilateral development partners include New Zealand, Japan, and increasingly US government with a supplementary focus on strengthening governance and reducing gender-based violence. Churches and NGOs play an especially important role in providing services in rural parts areas, particularly in primary and curative health, education and social protection.

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<sup>46</sup> NSO, 2016, Fertility Monograph (draft)

<sup>47</sup> NSO, 2016, Fertility Monograph (draft)

<sup>48</sup> World Bank, PNG country partnership strategy FY2013-2016

Table 5: Official Development Assistance to PNG in 2015, selected donors<sup>49</sup>

Source	Amount (US\$ m)	% GDP <sup>50</sup>
<b>1. Bilateral - DAC countries</b>	<b>464,23</b>	2.75%
Australia	418,31	
New Zealand	22,76	
Japan	9,28	
US	6,98	
UK	1,81	
Other bilateral	5,09	
<b>2. Multilateral</b>	<b>113,05</b>	0.67%
ADB	37,76	
World Bank IDA	30,69	
GFATM	16,00	
EU	14,40	
<b>UNFPA</b>	<b>1,94</b>	<b>0.01%</b>
Other multilateral	12,26	
<b>3. Others (NGO etc.)</b>	<b>0,05</b>	
<b>Total ODA</b>	<b>577,33</b>	3.41%

### 3. UNFPA RESPONSE AND PROGRAM STRATEGIES

#### 3.1 UN SYSTEM RESPONSE IN PNG

PNG is a Delivering as One (DaO) country since 2006. This means that all UN agencies plan and operate jointly, to simplify and harmonize the UN's contribution to national development. The United Nations Development Assistance Framework (UNDAF) outlines the UN system strategic program framework in PNG. The UNDAF Action Plan operationalizes the UNDAF, utilizing national systems and procedures for program delivery to reduce transaction costs. The current UNDAF and Action Plan were planned for 2012-2015. However, the GoPNG and UN system extended the UNDAF until 2016-2017 to align with GoPNG's Medium Term Development Plan 2. The UNDAF is themed 'Supporting PNG to accelerate MDG Achievement'. The result framework contains four clusters, each with an outcome. Ten inter-agency outcomes support the four cluster outcomes, each with several outputs.

Table 6: UNDAF results and interagency outcomes 2012-2015

<sup>49</sup> Source <http://stats.oecd.org/Index.aspx?datasetcode=TABLE2A>

<sup>50</sup> US\$ 16.93 billion as of 2014

<p><b>Governance for Equitable Development</b></p> <ol style="list-style-type: none"> <li>1. Governance <ul style="list-style-type: none"> <li>• Parliament and Local Governance</li> <li>• Financial Inclusion, Management and Transparency</li> </ul> </li> <li>2. MDGs &amp; Population <ul style="list-style-type: none"> <li>• Aid Effectiveness</li> <li>• MDG Advocacy &amp; Monitoring • Population &amp; Development</li> </ul> </li> <li>3. Peace-building   Bougainville</li> </ol>	<p><b>Social Justice, Protection &amp; Gender Equality</b></p> <ol style="list-style-type: none"> <li>4. Promotion &amp; Protection of Human Rights</li> <li>5. Gender Equality &amp; Women’s Empowerment <ul style="list-style-type: none"> <li>• Women in Leadership</li> <li>• Gender Based Violence • Child Protection</li> </ul> </li> <li>6. HIV &amp; AIDS</li> </ol>
<p><b>Access to Basic Services</b></p> <ol style="list-style-type: none"> <li>7. Health <ul style="list-style-type: none"> <li>• Maternal &amp; Child Health</li> <li>• Health Systems Strengthening</li> <li>• Communicable Diseases</li> </ul> </li> <li>8. Education</li> </ol>	<p><b>Environment, Climate Change &amp; Disaster Risk Management</b></p> <ol style="list-style-type: none"> <li>9. Environment, Climate Change and Sustainable Livelihoods</li> <li>10. Disaster Risk Reduction, Preparedness &amp; Response</li> </ol>

Program harmonization and coordination is enhanced through the work of originally ten, later eight UN Task Teams, organized per UNDAF priority outcome. UN Task Teams jointly agree Annual Work Plan (AWP) with their respective GoPNG counterparts and other stakeholders, specifying outputs, activities and resources allocations. Task teams report biannually (currently annually), based on progress reports from all members. Annually, the UN produces an UNDAF annual progress report.

The UNFPA 5<sup>th</sup> country program is aligned with the UNDAF, and implementation is through the 5 UN task teams, which are relevant to UNFPA’s mission.

*Table 7: UN task teams and UNFPA membership.*

UN Thematic task team	Lead* and members agencies
1. Governance	UNDP, UNCDF, UNFPA, UNICEF
<b>2. MDGs &amp; Population</b>	UNDP, <b>UNFPA</b> , UNICEF, WHO
<b>3. Peace-building Bougainville</b>	UNDP, OCHA, OHCHR, UNESCO, <b>UNFPA</b> , UNHCR, UNICEF, UNW, WHO
4. Human Rights	OHCHR, IOM, UNAIDS, UNDP, UNESCO, UNHCR, UNICEF, UNW, WHO
<b>5. Gender Task Team</b>	UNW, OHCHR, UNAIDS, UNDP, <b>UNFPA</b> , UNHCR, UNICEF, WHO
6. Child Protection	UNICEF, UNHCR
<b>7. HIV/AIDS</b>	UNAIDS, UNDP, UNESCO, <b>UNFPA</b> , UNICEF, UNODC, UNW, WHO
<b>8. Health</b>	WHO, UNICEF, <b>UNFPA</b>
9. Education	UNICEF, UNESCO
10. Environment, Climate	UNDP, FAO, UNEP, WHO

UN Thematic task team	Lead* and members agencies
11. Disaster Risk Management <sup>51</sup>	OCHA, UNDP, UNFPA, UNHCR, UNICEF, UNW, WHO

\*The lead agency is mentioned first

## 3.2 UNFPA PNG COUNTRY PROGRAM

### 3.2.1 PREVIOUS UNFPA COUNTRY PROGRAM ACHIEVEMENTS AND LESSONS

The 4<sup>th</sup> UNFPA country program (2008-2012) was also integrated in the joint UNDAF strategic framework. The UNFPA Country Program Document outcomes were:

1. Comprehensive, high-quality *sexual and reproductive health information and services*, including HIV/AIDS prevention services, will be available to and used by greater numbers of women, men, adolescents and youth
2. The three levels of Government (national, provincial and district) fully implement the national population policy, with *population issues reflected in planning and monitoring documents*
3. Institutional *mechanisms are strengthened to address key gender issues*, with a focus on gender-based violence; gender stereotyping in schools and in the labor force; and implementation of the Convention on the Elimination of All Forms of Discrimination against Women

Whilst the 4<sup>th</sup> Country Program has not been evaluated, key achievements are presented in the (Common) Country Program Document 2012-2015. The CCPD is a joint document with UNDP and UNICEF; hence some of the achievements below are not specific to UNFPA:

1. UN support included technical assistance, upstream policy advice, advocacy, downstream interventions and the role of convener and broker.
2. Achievements included 1) strengthening national capacities in gender-sensitive needs assessment and costing in health 2) development of the National Health Plan 2011-2020; and 3) review of relevant policies to improve service delivery for child survival and maternal health.
3. The National Population Policy was developed and implemented, and disaggregated data for better integration of population-related issues in national and provincial planning and budgeting were presented.
4. Advisory support was provided for the preparation of the first national report on implementation of the Convention on the Elimination of All Forms of Discrimination against Women and a complementary 'shadow report' by a national NGO.
5. Violence against women was addressed on several fronts: (a) the police; (b) the educational system, working with men and boys; and (c) providing support services for victims of violence.
6. As convener, the United Nations facilitated dialogue and South- South cooperation on issues including protection systems for women and girls against violence.

<sup>51</sup> Task teams 10 and 11 have merged

### 3.2.2 THE 5<sup>TH</sup> UNFPA COUNTRY PROGRAM

The 5<sup>th</sup> UNFPA country program (2012-2015) is integrated in the UNDAF, and described in a Common Country Program Document (CCPD) with UNICEF and UNDP. The CCPD contains a *UNFPA specific* results and resource framework, which guides the country program implementation<sup>52</sup>. In 2015 the UN Executive Board UNFPA agreed an extension for the years 2016-2017. The indicators in the result and resource framework was reviewed and revised in 2015<sup>53</sup>.

The outcomes for the 5<sup>th</sup> PNG country program are clustered around the corporate UNFPA priority areas<sup>54</sup>: 1) sexual and reproductive health & rights; 2) population and development; and 3) gender.

UNFPA outcome	related UNDAF outcome
1. The capacity of the GoPNG and relevant stakeholders is strengthened to improve the quality of, access to and utilization of maternal, newborn, child and adolescent health services, including services for sexual and reproductive health;	Access to basic services
2. The GoPNG and its partners have strengthened their capacity to achieve the goals and strategic priorities of the national HIV/AIDS strategy;	Social justice, protection and gender equality
3. Relevant GoPNG bodies engage in data-based, evidence-based and participatory policymaking, planning and budgeting to achieve, with equity, the MDGS;	Governance for equitable development
4. Women, men, boys and girls have increased opportunities to access resources, rights and decision-making processes through equal participation in and benefits from the economic, social and political development of PNG; and	Social justice, protection and gender equality
5. UNFPA country office has strengthened capacity for program coordination, monitoring and evaluation.	

The CCPD results and resources framework provides for each outcome the relevant national and UNDAF outcome it contributes to; several indicators; implementing partners; and a tentative resource envelope

Many interventions and activities were planned annually to contribute to each outcome<sup>55</sup>. Broad areas for support activities under each of the outcomes are 1) support for national policy development and normative guidance; 2) support for systems strengthening at provincial level; and 3) support for direct service delivery. Four priority provinces are identified to support the translation of national level, upstream policy support to local level systems strengthening and service delivery: 1) the Autonomous Region of Bougainville; 2) Central Province; 3) Enga Province; and 4) Morobe Province.

<sup>52</sup> See Annex 6.

<sup>53</sup> See Annex 6.

<sup>54</sup> As of 2012 'Adolescent sexual and reproductive health' was not yet a separate UNFPA strategy

<sup>55</sup> Annex 3 provides all planned activities, and outputs achieved.

## **1. Sexual & reproductive health & rights**

### **1.1 National SRHR Policy development and advocacy**

- NDOH advocacy on FP and RH policy development
- NDOH support for ASRH policy development
- DoE support for HIV & Comprehensive Sex Education curriculum
- NACS update out-of-school HIV peer education guidelines
- MDG Radio Advocacy campaign
- NYDA develop Youth Policy

### **1.2 Provincial health system strengthening**

- FP awareness forums for provincial decision makers
- Provincial roll out MSI/NDOH FP training
- Provincial roll out RHTU/NDOH EOC/EMOC training
- IPPF regional training on SRH services in emergencies
- NYDA establish/strengthen provincial youth councils
- NACS support for 4 Provincial AIDS Committees to organize youth IEC, leadership
- NYDA and WVI organize mock youth parliaments in ARB

### **1.3. Support service delivery**

- YWCA radio program on SRH
- YWCA out of school peer education on HIV & RH
- UPNG peer education on HIV & RH
- Self-management training youth
- Establishment of 3 youth centers

## **2. Population and development**

### **2.1 Policy development and advocacy**

- DNPM to revise/ratify national population policy, and national population days
- NSO document and disseminate 2011 Census
- NSO publication of census-based population monographs
- NSO undertake/disseminate 2016 DHS
- NSO set up vital registration at village level

### **2.2 Capacity building for provincial policy implementation and roll out**

- NSO document and disseminate 2011 Census provincial reports

### 3. Gender equality and women's empowerment

#### 3.1 Institution building

- Organizational support for NCW
- NCW strengthen provincial women councils

#### 3.2 National policy development and advocacy

- NCW to write CEDAW shadow report

#### 3.3 Health sector response to GBV

- Revision GBV manual for health workers
- FSVAC develop reporting forms for Family Support Centers
- Provincial health sector response to GBV

#### 3.4. Sectoral responses to GBV

- National level law enforcement response to GBV (police Training Manual on GBV; sensitization senior management; develop reporting system.
- Provincial law enforcement response to GBV (train officers on GBV; baseline assessment on GBV reporting & prosecution of GBV)
- FSVAC community awareness on GBV, training village court/district/court magistrate/lawyers
- Youth response to GBV: FSVAC youth training & NYDA student leaders on GBV

### Implementation

Whilst the CCPD result framework aligns with UNFPA corporate priority teams, the UNFPA program activities were largely implemented (monitored and reported) in the context of UN task teams and towards UNDAF outcomes and outputs. UNFPA agreed some additional projects, some of which were not relevant to the respective task team result (see Table 7). The table also indicates some overlap between HIV and (A)SRH projects, and between adolescent versus 'adult' programming.

Table 8: Links between UNFPA projects/programs and UN task teams

UN task team	UNFPA strategic programs				Additional projects			
	SRHR & HIV	ASRH & HIV <sup>56</sup>	Pop & Dev.	Gender	Youth & peace	RHC Supplies	MISP <sup>57</sup>	DHS 2016
MDGs & Population			X					X
Peace-building Bougainville					X			
Gender Task Team				X				
HIV/AIDS	X	X						
Health	X	X				X		

<sup>56</sup> Inclusion of ARSH reflects the current UNFPA strategy, used for the CPE

<sup>57</sup> Training for emergency reproductive health service programming

The modus operandi for UNFPA is to collaborate with GoPNG counterparts, who may or may not implement activities (and receive funding) themselves, depending on capacity. Government partners are:

- Department for National Planning and Monitoring (DNPM) for population policy
- National Department of Education (NDoE) for adolescent SRH programming
- National AIDS Council Secretariat (NACS) for HIV prevention programming
- National Department of Health (NDOH) for SRH policy and programming
- National Research Institute (NRI) for population research
- National Statistical Office (NSO) for census and DHS
- Royal PNG Constabulary (RPNGC) and NDOH for gender based violence responses

Where possible, project activities are subcontracted to implementing partners, including NGOs and public private partnership. These are:

- Family & Sexual Violence Action Committee (FSVAC) under Institute of National Affairs (INA)
- International Planned Parenthood Federation (IPPF) for family planning
- Marie Stopes International (MSI) for family planning training and services;
- National Council of Women (NCW) for gender empowerment
- National Youth Development Authority (NYDA) for adolescent SRH
- Population Media Center (PCM) for mass awareness
- University of PNG (UPNG) for peer education among university students
- World Vision International (WVI) for adolescent programming
- Young Women's Christian Association (YWCA) for peer education & media

### 3.2.3 FINANCIAL STRUCTURE OF THE PROGRAM

Funding for the 5<sup>th</sup> UNFPA country program was largely raised as core budget from UNFPA head quarters, to implement activities planned under UNDAF operational plan. Additional funding for planned UNDAF activities could be raised jointly with other agencies, for example through the one UN fund, or the UN Peace building fund. UNFPA also mobilized additional unplanned funding, for example to support the DHS 2016 (DFAT), for adolescent programming in ARB (DFAT with WVI), and for commodity procurement and supply management (UNFPA). Finally, UNFPA undertook activities that were funded in the context of regional UNFPA initiatives, e.g. the MISP training for reproductive health services in humanitarian situations.

Whilst the level of core funding for the UNFPA country program steadily declined since 2012, UNFPA PNG was able to raise additional resources to compensate this. UNFPA country office data are not complete (see figure 9) but indicate annual program budgets decreasing from US\$ 2 to 0.5 million from 2012. Thanks to a single large DFAT grant (A\$ 10 m) to support the DHS 2016 implementation and analysis, the overall resource envelope for UNFPA has increased during the period 2012-2016. Annual expenditure rates were reportedly high, around 90%<sup>58</sup>.

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<sup>58</sup> Pers. comm. Walter Mendonca-Filho



Table 9A: Funding allocations<sup>59</sup> for implementing partners (2012 - 2016)

Partner	2012 US\$	2013 US\$	2014 US\$	2015 US\$	2016 US\$	Total amount
NSO	10,000	67,400	-	50,000	3,891,333	4,018,733
NDOH	648,111	430,806	336,000	231,000	160,000	1,805,917
DNPM	312,000	193,512	164,000	10,000	20,000	699,512
INA	286,504	186,000	75,000	55,000	60,000	662,504
NYC	113,000	101,600	73,500	86,626	-. <sup>60</sup>	374,726
DOE	150,000	194,000	15,000	12,200	-. <sup>61</sup>	371,200
UPNG	147,000	75,000	45,000	49,800	40,000	356,800
YWCA	100,000	75,000	55,000	50,000	55,000	335,000
NCW	53,000	120,000	67,000	41,000	-. <sup>62</sup>	281,000
PMC	100,000	110,088	- <sup>63</sup>	-	-	210,088
NACS	-. <sup>64</sup>	-	-	-	-	-
<b>Total</b>	<b>1,919,615</b>	<b>1,553,406</b>	<b>830,500</b>	<b>585,626</b>	<b>4,226,333</b>	<b>9,115,480</b>

In terms of financial management, the 'One UN Fund' is used to jointly manage the majority of the UNFPA resources (that support UNDAF task team outputs). Using this fund for additional project funding (e.g. the DHS 2016 management) facilitates financial and progress reporting, because separate reports are not required.

Table 9B<sup>65</sup>. Allocation of UNFPA resources to program areas

Program area	Total allocation 2012-2016 <sup>66</sup>	% allocation 2012-2016
Pop & Dev	4.928.333	54,07%
SRH/ASRH	2.140.917	23,49%
ASRH	1.102.726	12,10%
gender	943.504	10,35%
	<b>9.115.480</b>	

<sup>59</sup> Note: 1) these are not annual expenditures but resource allocations; 2) partners budgets which are directly managed by UNFPA are not included here (e.g. HIV project budget for NACS) – source UNFPA CO.

<sup>60</sup> Since 2016 direct management by UNFPA

<sup>61</sup> Partnership terminated

<sup>62</sup> Direct management by UNFPA

<sup>63</sup> Partnership terminated

<sup>64</sup> NACS funding not reflected because managed directly by UNFPA (C. Milford, pers. comm.)

<sup>65</sup> For more detail see table 17, page 62

<sup>66</sup> see table 9A for assumptions underlying estimates

## 4. FINDINGS: ANSWERS TO THE EVALUATION QUESTIONS

This chapter presents the findings of the evaluation for each of the 10 evaluation questions. The assumptions of the evaluation matrix are discussed (see Annex 4) and key findings are summarized. Document review and stakeholder interviews did not reveal any materially relevant unintended consequences.

### 4.1 RELEVANCE OF THE UNFPA COUNTRY PROGRAM

Evaluation question: To what extent is the UNFPA support (i) adapted to the needs of the population; and (ii) in line with the priorities set by the international and national policy frameworks? Do planned interventions adequately reflect the goals stated in the Common Country Program Document (CCPD)?

#### Summary of the answer:

**The UNFPA country program is relevant to the needs of PNG and its government, especially support for population policy development, and for policy implementation at subnational level. UNFPA support for SRH and gender based violence is highly relevant for PNG, but support for service delivery is not in line with UNFPA guidance for middle income countries. The country program as a whole and individual interventions are not designed with evidence from formative research<sup>67</sup> (needs assessment or problem analysis), which may limit their relevance. Although 50% of the population is under 19, UNFPA adolescent SRH programming is limited.**

**Relevance finding #1: UNFPA support in the area of population and development is highly relevant, because PNG is experiencing population growth that threatens sustainable development and the GoPNG requested support from development partners.** Family planning strategies and programming are directly responding to the population policy priorities and therefore support in this area is also highly relevant.

**Relevance finding #2: The 5<sup>th</sup> UNFPA program is not informed by evidence from formative research on needs or problems.** The UNFPA program relies on a joint UN needs assessment, which is relevant in the context of the broader UNDAF, but failed to provide the evidence needed for needs-based programming in the area of sexual and reproductive health and rights. A thorough SRH situation analysis undertaken in 2014 for the Supplies project recommends broad strategies, but this report is not widely known in the team or used beyond the Supplies project.

**Relevance finding #3: UNFPA focus on priority provinces is highly relevant to the need to turn supportive policies into stronger local health and community systems for service roll out.**

<sup>67</sup> Formative research is research conducted before a program or activity is designed and implemented, to help identify answers to these questions. This type of research is also referred to as needs assessment.

However, there were no clear selection criteria for priority provinces, nor has there been formative research to assess local opportunities and needs for UNFPA programming.

**Relevance finding #4: UNFPA’s support for policy development and system strengthening is relevant, while direct support for service delivery is not relevant.** PNG is labeled as an “orange country” which means the focus of UNFPA support should be ‘upstream’ rather than supporting services directly. Current support for service delivery (family planning, self management clinics, peer education) is not relevant for upstream work, as it does not aim to inform policies or program design.

**Relevance finding #5: The UNFPA program has limited relevance to adolescents’ sexual and reproductive health needs.** There is an enormous need for policies, guidelines and operational research in this area, and tremendous potential in the large cohort of young people that could be involved. The current UNFPA support for adolescent programming around peace building has no demonstrable relevance to adolescent sexual and reproductive health.

**Relevance finding #3: The human rights aspects of the ICPD agenda are not comprehensively addressed in the UNFPA program, despite opportunities and need.** Examples of need and demand in PNG are common denial of family planning to (young) women; access to safe abortion; reproductive rights of women with HIV; and sexual orientation and gender identity (LGBT) issues. Whilst the current program and team are sensitive to human rights issues, there is limited explicit programming.

Assumptions	Evidence
1. The UNFPA CCPD and relevant AWP contain a needs assessment, where possible participatory	<ul style="list-style-type: none"> <li>• Evidence of needs assessment before to programming the CCPD &amp; AWP</li> <li>• Extent to which UNFPA supported interventions targeted the most vulnerable, disadvantaged, marginalized and excluded population groups in a prioritized manner.</li> </ul>
2. CCPD and AWP strategies and objectives respond to national development priorities	<ul style="list-style-type: none"> <li>• Extent to which objectives and strategies of each component of the program are consistent with relevant national and sectorial policies</li> <li>• Extent to which the objectives and strategies of the CCPD have been discussed and agreed upon with the national partners</li> </ul>
3. CCPD and relevant AWP are consistent with UNDAF and UNFPA strategic plan objectives and strategies.	<ul style="list-style-type: none"> <li>• Extent to which objectives and strategies of each component of the program are consistent with the UNDAF and its guiding principles</li> <li>• Extent to which objectives and strategies of each component of the program are consistent with the UNFPA global strategy and ICPD principles</li> </ul>

**Assumption #1: UNFPA program and project documents (CCPD and AWP) contain limited evidence from (participatory) needs assessments.**

**Whilst the UNFPA Common Country Project Document contains a limited situation analysis,**

**the Joint Annual Work plans do not contain any needs assessment.** UNFPA did not undertake an evaluation of the 4<sup>th</sup> country program (2008-2012), therefore missing an opportunity to identify lessons learnt. For the design of the 5<sup>th</sup> country program, UNFPA relied on the joint UN country analysis undertaken for the development of the UNDAF. The situation analysis in the UNDAF<sup>68</sup> is three pages and does not provide much detail on SRH and population issues. The CCPD<sup>69</sup>, which is developed jointly with UNDP and UNICEF contains a situation analysis, but little detail on the problems that UNFPA addresses, other than 3 paragraphs on gender, HIV and health in general. The task team annual work plans (AWP)<sup>70</sup> do not contain needs assessments or lessons, just outcomes and outputs. Besides, these work plans are not UNFPA specific, but for the five UN task teams that UNFPA participates in.

The evaluation found no evidence that UNFPA program activities, especially those subcontracted to implementing partners, are based on project documents including situation analysis and rationale (and objectives). Although UNFPA staff and partner organizations expressed agreement on the need and relevance for most activities, many of these activities and projects are not evidence based, and have questionable relevance (and effectiveness, see later). Examples of projects without needs assessment or rationale include training of peer educators for out of school youth, community based leadership training on gender-based violence.

Some UNFPA project proposals (submitted beyond the scope of the UNDAF core program) include evidence of a situation analysis. One example is the Bougainville Youth Project document<sup>71</sup> (submitted by World Vision International), which includes a situation analysis. The second example is the UN Peace-building Fund application<sup>72</sup>, which refers to a 'Peace & Development Analysis' and a joint UN study. Unfortunately neither proposal covers sexual and reproductive health issues, thus limiting the relevance for UNFPA's core business.

UNFPA has not supported formative or operational research *as a country program activity*, to generate evidence on established SRHR challenges in PNG, for example demand side and supply side barriers to service improvement, the potential of civil society to respond to GBV, sexual and reproductive rights, most at risk groups for HIV, adolescent sexual health issues, etc. A research area often mentioned by key informants is the nexus between national policies and their implementation at local level, including barriers at provincial level.

**UNFPA support for policy development prioritizes the most vulnerable, but UNFPA supported interventions are not evidently targeting the most vulnerable.** Policy advocacy and normative guidance from UNFPA alone or with other UN agencies, aims to 'leave no one behind'. The health and population policies developed with UNFPA support tend to include ample provisions about human rights, and aim for inclusion and equity. Examples are the gender and health policy, adolescent health policy and indeed the population policy. As mentioned above UNFPA has not invested in operational research as a support modality to generate strategic information on vulnerable groups or specific barriers to SRH services.

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<sup>68</sup> UNDP, 2012, UN Development Assistance Framework 2012-2015

<sup>69</sup> UNDP, UNICEF, UNFPA, 2011, "Final Common Country Programme Document 2012-2015"

<sup>70</sup> AWP for the five Task Teams UNFPA participates in – 2012-2015

<sup>71</sup> WVA, 2011, 'Approved Proposal to DFAT'

<sup>72</sup> PBSO, 2015, 'Project Document: Promoting security and social cohesion in Bougainville'

Some of the interventions supported by UNFPA through implementing partners do not seem to address the most vulnerable subgroups. Examples are peer education for university students in the capital city, where evidence suggests that younger, less educated and unemployed youth are much more at risk (but harder to reach). In general, “adolescents” targeted and reach by UNFPA partners tend to be older than 25, although the vulnerability of younger adolescents is much higher. Whilst the National Council of Women, the women’s platform supported to increase the voice of women, struggles to represent and give voice to the most vulnerable women of PNG, the evaluation team met several alternative women’s representatives and voices in the police, health sector, academia, and media. Finally, UNFPA is mandated to target HIV intervention on key populations including (female and transgender) sex workers, who are most at risk in PNG, but UNFPA invests more in targeting students and youth.

The UNFPA country program prioritizes four provinces for support at local level, but the choice of these provinces does not seem to be based on an assessment of need. The CCPD does not explain or justify the choice priority provinces. Bougainville is a UN priority due to the post conflict peace building efforts, and a joint UN family health assessment was done in 2012-3<sup>73</sup>.

**Assumption #2: CCPD and AWP strategies and objectives respond to national development priorities.**

**The CCPD objectives are consistent with relevant national and sectorial policies, and the strategies of each component of the program are largely consistent.** The CCPD derives directly from the UNDAF, which is a document that reflects GoPNG priorities for UN support. There is no evidence that government priorities have changed since the inception of the program, and the UNDAF remains largely relevant to GoPNG priorities. National development outcomes are reflected in the UNDAF result framework, and in turn UNDAF outcomes are reflected in the CCPD results framework<sup>74</sup> (and of course the joint work plans of the UN task teams).

UNFPA’s support for *population and development policy development* is consistent with national priorities. The Prime Minister and Minister for Planning both consider sustainable population growth as a key development priority, and appreciate the importance of evidence based planning. The national statistics office requested UNFPA support for the 2016 DHS, which is indicative of leadership commitment. From the perspective of the planning department, the priority for UNFPA support to the health sector is family planning, as this has the most direct influence on population.

UNFPA’s support for *SRHR* policy development and systems strengthening is consistent with health sector priorities. Now that NDOH has issued several policies that are rights based (with support from UNFPA and partners), the next challenge is how to turn supportive policies into health services and improve reproductive health outcomes: the challenge is at provincial and lower levels. In interviews, provincial health authorities (in Morobe and ARB) requested more support for planning and strategizing, including human resource development. The national AIDS strategy is revised in view of the evidence that PNG has a concentrated epidemic among key populations (female and transgender sex workers, and MSM). As mentioned previously,

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<sup>73</sup> Jukes R. et al, 2013, Family Health and Safety Study, Autonomous Region of Bougainville

<sup>74</sup> See annex 4 – UNFPA CCPD result framework

UNFPA's support does not yet fully reflect this revised focus, as it continues to invest in peer education for students and out of school youth without assessing vulnerability or behavioral outcomes.

UNFPA's corporate priority of *adolescent sexual and reproductive health* is consistent with PNG priorities. Although ASRH is not a specific CCPD outcome, UNFPA developed several specific ASRH strategies and interventions. The GoPNG recognizes that more than 50% of the population is under age 19, and that this generation is not only coming of age, but also that young people are the key to challenging perceptions about gender inequality, reproductive rights, and to economic and social development. Provincial health managers mentioned that young people need to replace the ageing cohort of health workers, and need investment in pre-service training. Community development officers and youth representatives request support to organize young people.

UNFPA's work on *gender* is focused on gender based violence, and gender review of health policies. The high prevalence of gender based and sexual violence is recognized as a cross cutting challenge in PNG, and the UN's support (including UNFPA) to sectoral responses (in health and law enforcement) is consistent with national needs. In terms of gender review, the NDOH has reviewed and revised several policies (gender and health, family planning) to specifically address gender inequality. Local government and civil society representatives expressed that support is needed to turn these policies into local action.

**Objectives and strategies of the CCPD have been discussed and agreed upon with the national partners.** The UNFPA CCPD and relevant AWP, like the UNDAF, are agreements signed between the UN and government counterparts. Relevant counterparts sit on overall UNDAF as well as task team/AWP steering committees, and are closely involved in progress monitoring. Government involvement in UNFPA planning is made more effective in the joint UN response. NDOH informants express that UNFPA support is relevant in view of national priorities: the majority of UNFPA finances is spent on facilitating NDOH core processes such as staff, health worker training and procurement of reproductive health commodities. By far the largest UNFPA project (US\$ 7.4 m) is the support for DHS 2016, which is at the direct request of the Planning Department.

**Assumption #3: CCPD and relevant AWP are consistent with UNDAF and UNFPA strategic plan objectives and strategies.**

**The objectives and strategies of each component of the program are consistent with the UNDAF and its guiding principles.** PNG is one UN country since 2006, and the current UNFPA country program is designed and implemented in the context of the UNDAF strategy and operational plan. UNFPA participates in 5 joint UN task teams, and implements its interventions largely in close cooperation with UN partners, especially in the area of health policy development (with WHO and UNICEF) gender based violence (with UNDP and UNW), and HIV responses (UNAIDS).

**Objectives and strategies of each component of the program are partly consistent with the UNFPA global strategy and ICPD principles.** The CCPD 2012-2015 partly aligns with the UNFPA global strategy 2014-2018, which is because the country program predates 'adolescent sexual

health' a separate corporate program. Probably as a consequence, the adolescent SRH component of the UNFPA country program is least relevant. The HIV peer education interventions are not evidence based and poorly targeted; the peace building activities for adolescents in Bougainville (mock parliament, self management clinics) and the establishment of provincial youth councils do not directly impact SRH outcomes.

UNFPA's focus on direct service delivery is not consistent with corporate guidance. PNG is labeled an 'orange country' which means UNFPA support can focus on policy dialogue, normative support and knowledge management. Direct service delivery can still be useful, as long as doing so feeds into upstream policy or normative work<sup>75</sup>. Yet, the UNFPA country program contains several direct service delivery activities, including family planning services (MSI); peer education for youth (UPNG, YWCA); and self-management clinics for young adults. The recent UNDAF evaluation also recommended that the UN should work better to their comparative advantage and 'review direct implementation and expand modalities to strengthening national capacities; international norms and standards; convener of partners; technical expertise; policy advice'<sup>76</sup>. That said, several informants argue that the extreme inequalities in PNG and the deteriorated economic forecasts, warrant a re-assessment of PNG as an orange country.

The UNFPA country program does not fully cover the sexual and reproductive rights components of the ICPD agenda. This is so, although the overall UNDAF has a strong focus on human rights, and the ICPD is explicitly concerned with reproductive and sexual rights. Reproductive rights are highly relevant to PNG, given the religious and male opposition to family planning options<sup>77</sup>, and attempts to address decriminalization of sex work and homosexuality, in the context of reducing HIV vulnerability<sup>78</sup>. A recent report identified sexual and reproductive rights of women living with HIV as a neglected area<sup>79</sup>.

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<sup>75</sup> UNFPA, 2014, UNFPA Strategic Plan 2014-2018

<sup>76</sup> Lund et al, 2016, UNDAF evaluation report

<sup>77</sup> several key informants and UNFPA, 2014, situation analysis

<sup>78</sup> pers. comm. UNAIDS Country Director

<sup>79</sup> SCA, 2016, Poro Sapot Evaluation

## 4.2 PROGRESS OF UNFPA SEXUAL AND REPRODUCTIVE HEALTH INTERVENTIONS

### 4.2.1 GENERAL EFFECTIVENESS FINDINGS

Overall effectiveness question: To what extent has the 5<sup>th</sup> UNFPA Country Program has made progress towards the CCPD results framework?

**Summary of the answer:**

**The CPE could not assess progress towards the CCPD result framework for several reasons. First, the CCPD result framework is not used to monitor or report progress because PNG is a One UN country; UNFPA tracks progress as part of Joint UN Work plans and reports through 5 different UN task teams. Second, the CCPD result framework is problematic for measuring progress: some results are not specific; some indicators are not measurable or have no baselines; and the result framework was revised mid term. Third, specific UNFPA interventions cannot be evaluated for effectiveness because most of them have no stated objectives or indicators for success. Finally, UNFPA monitors only expenditures against allocated budget (burn rate).**

**Effectiveness finding #1: Because the UNFPA PNG country program is integrated within the joint UN strategy, work plan and result framework, there is little rationale or incentive for UNFPA PNG to undertake its own M&E.** As mentioned earlier, UNFPA does not develop its own work plan, instead each UNFPA activity contributes to joint outputs in one of five UN task teams, and progress is monitored *jointly* (led by the task team lead agency). UNFPA PNG does not produce a country program progress reports against the CCPD result framework.

**Effectiveness finding #2: The CCPD result framework is not useful to measure program effectiveness, because 1) the result framework was significantly revised during implementation, 2) outcome indicators are problematic, and 3) the result framework has not been used for monitoring and recording progress.** First, in 2016 the result framework was revised to include an extra outcome (related to HIV, but not to adolescent sexual health), and two additional layers of results and indicators. Second, indicators in the 2012-2015 result framework, and the revised 2016-2017 framework, were not conducive to M&E, for example:

- None of the indicators specify the means of verification to measure progress
- Some indicators do not specify a baseline (nor plan to develop a baseline), e.g. the prevalence of GBV and the percentage women with a say in family planning decisions. In the 2016 revision of the result framework the same indicators were used, again without a baseline.
- Outcome indicators in the 2016 revision of the result framework do not have realistic baselines, but the same baseline (and targets) as in 2012.
- Some outcome indicators rely on DHS/Census and are not useful to track more regularly, e.g. age specific fertility rate
- Many outcome level indicators are not specific to UNFPA's contribution in joint activities, e.g. contraceptive prevalence rate, skilled birth attendance rate, condom use rates, budget allocation to MDG priorities, and GBV prevalence.

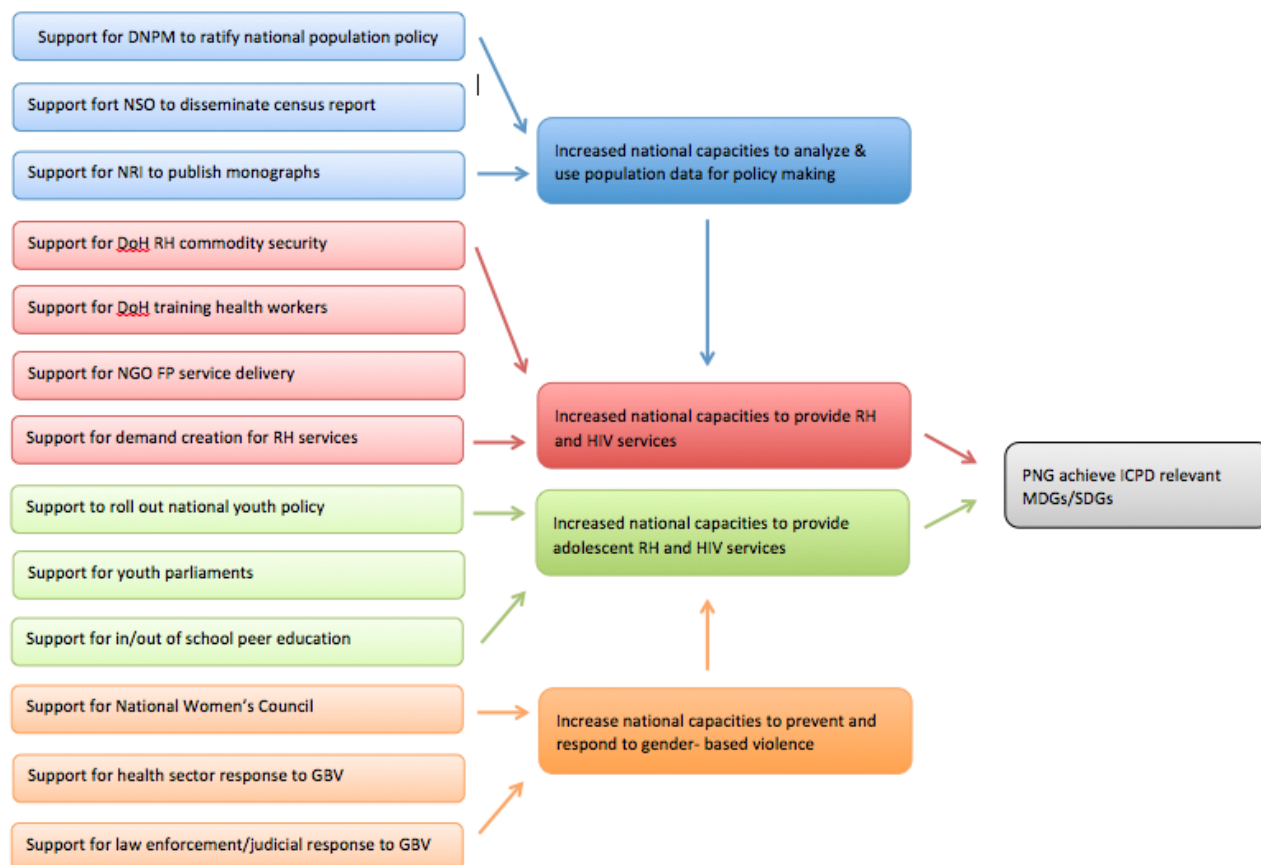


- Some outcome indicators are not measurable from routine data, only through specific research, e.g. GBV prevalence, government budget allocation to MDG priority sectors, and advocates' prosecution rates for GBV.
- Some outcome indicators are not specific for UNFPA's target audience, e.g. condom use by adults, whereas the HIV programming is targeting youth.
- Conversely, the outputs indicators for HIV (national sex education curriculum in place) does not contribute to the outcome indicator (condom use by adults)
- Some output indicators don't reflect an actual UNFPA activity, e.g. men's desks established in provinces, or an NSO website established and used.

Finally and most importantly, UNFPA has not used the result framework to monitor progress, largely because all activities contribute to joint UNDAF results and it was left to joint UN task teams to monitor progress towards joint work plan outcomes and outputs. UNFPA guidance on CPE recognizes the limitations of CCPD result frameworks, therefore the designs report proposed an evaluation matrix with specific indicators and sources of information to test assumptions on effectiveness (see Annex 4).

**Effectiveness finding #3: The UNFPA program does not have an intervention logic for the overall program, and individual activities and interventions do not specify objectives, indicators for success or indicators.** First, the UNFPA country program does not specify an overall goal to which the 4 outcomes contribute, nor does it explain how the program components and subcomponents relate and support each other. Second, even individual activities such as support for health worker trainings and radio programs do not specify the desired outcomes in terms of behavior, knowledge, skills or attitudes nor are these assessed. The design report proposed an intervention logic for the country program.

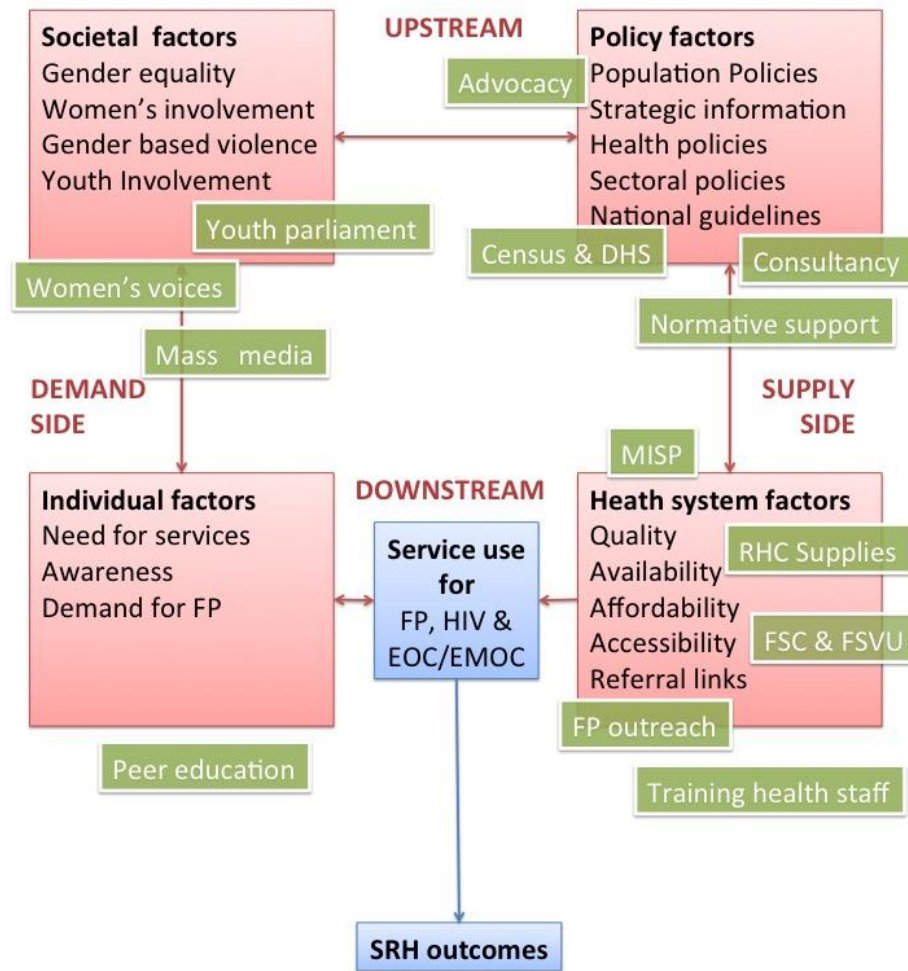
Figure 2: Proposed intervention logic for the UNFPA PNG Country Program



During the evaluation, the team developed a theoretical framework for the country program:

1. The proposed overall goal is improved SRH outcomes, to be achieved through increased use of services
2. Use of services is determined by demand side (user) and supply side (health service) factors. This is the realm of 'downstream' support: e.g. training, supplies etc.
3. Policy environment and cultural factors influence services supply and demand; this is where UNFPA provides 'upstream' support, e.g. policy development and platforms for women/youth.

Figure 3: Theoretical framework for the UNFPA program and interventions



**Effectiveness finding #4: UNFPA PNG has not evaluated the effectiveness or impact of implemented projects or interventions, other than monitoring expenditures versus budget allocation (burn rate).** The evaluation team accessed only two evaluation reports: the end of project evaluation (2015) of the RHC supplies program, and an (2013) evaluation of the MDG radio program. It is possible that there are additional reports, but UNFPA PNG does not systematically document, share and use strategic information such as evaluations between programs and program officers. As a result, UNFPA program documentation contains no evidence of effectiveness. UNFPA implementing partners are not obliged to assess or report on the effectiveness of their interventions; one partner proposed an external evaluation of the self-management clinic, but UNFPA did not approve this<sup>80</sup>.

<sup>80</sup> pers. comm. NYDA M&E Manager

## 4.2.2 SPECIFIC EFFECTIVENESS FINDINGS

The evaluation question is: to what extent has the sexual and reproductive health interventions achieved outcomes in term of contraception, skilled delivery, and emergency obstetric care services?

**Summary of the answer:**

**UNFPA support for SRH has contributed to supportive national policies for SRH services and rights, but these policies are yet to translate in provincial level SRH strategies, systems and services. UNFPA support for health systems strengthening was effective for RH commodities security, resulting in fewer stock outs and provision of implants and female condoms to PNG. UNFPA facilitated roll out of health worker training in priority and non-priority provinces, but scale is too limited for impact. UNFPA has not evaluated effectiveness of specific SRH interventions, e.g. health worker training, family planning services or acceptability of new contraception methods.**

**Effectiveness finding # 5: UNFPA has contributed to significant progress in national policy development, although the specific contribution of UNFPA to the joint UN policy dialogue is hard to identify.** The GoPNG developed and/or revised a range of policy documents in the area of population and SRHR, most of them supporting key ICPD themes such as children by choice, gender, rights, GBV, and adolescents.

**Effectiveness finding #6: Stakeholders agree that there is limited progress in operationalization of supportive national policies at provincial and local levels.** This also applies to the four UNFPA priority provinces, despite an identified need and expressed demand for health system strengthening support.

**Effectiveness finding #7: UNFPA made some progress in supporting health systems strengthening at national and provincial level.** UNFPA supported NDOH on the supply and security of family planning commodities and gender training of senior health managers. There is less than anticipated progress on strengthening Family Support Center services for GBV victims.

**Effectiveness finding #8: UNFPA has facilitated the roll out of NDOH health worker training in priority (and other) provinces, but with limited impact on human resource capacity.** UNFPA enabled roll out of the MSI FP training and the RHTU obstetric care training, but the coverage remains too low for impact. UNFPA supported training on supply, security and stock management for health workers, resulting in reduced stock outs.

**Effectiveness finding #9: UNFPA has been instrumental in increasing the availability of implants (and female condoms) in PNG - but without formative research or operational research on demand and supply side challenges.** There is anecdotal evidence that implants are extremely popular among women, but also about severe resistance among male partners due to misconceptions.

**Effectiveness finding #10: UNFPA PNG contributed to the development of national HIV prevention (peer education) guidelines for female and transgender sex workers, and advocated for the decriminalization of sex work (which has yet to be approved by Parliament).**

Assumptions	Evidence
1. National policies agreed and operationalized that support the ICPD agenda regarding SRH and rights <sup>81</sup>	<ul style="list-style-type: none"> <li>•</li> </ul>
2. Provincial Health Departments (in project provinces) are able to plan, deliver and monitor SRH services	<ul style="list-style-type: none"> <li>• Evidence of provincial SRH strategic and operational plans</li> <li>• Evidence of increased health worker capacity in FP &amp; EOC</li> <li>• RHC security system in place and operational</li> <li>• Maternal death surveillance operational</li> </ul>
3. Comprehensive, gender-sensitive, high-quality SRH services are in place and accessible in underserved areas with a focus on vulnerable groups in project areas	<ul style="list-style-type: none"> <li>• Availability of SRH services increased, including FP, EOC, and Family support clinics</li> <li>• Uptake of EOC &amp; FP services increased, especially for vulnerable women and men</li> </ul>
4. Support for innovations resulted in improved national capacity for SRH services	<ul style="list-style-type: none"> <li>• MISP strategy and SOPs available</li> <li>• EOC baseline survey report</li> </ul>

**Assumption #1: National policies agreed and operationalized that support the ICPD agenda regarding SRH and rights.**

**The GoPNG agreed and/or drafted several policies that support the ICPD principles.** These policies are 1) National Population Policy (2015); 2) National Family Planning (2014); 3) National SRH Policy (agreed 2012); 4) National Gender & Health Policy (2014), and 5) National Youth & Adolescent Health policy 2014 (agreed 2012). These policies contain principles that are in line with international agreements, including human rights, gender equality and equity.

**UNFPA's support to above policies is recognized and appreciated by stakeholders, but is it impossible to determine attribution, because most policy support is done jointly with other development partners.** UNFPA PNG participates pro-actively in policy dialogue with relevant government counterparts, where the Country Representative provides political support and the Assistant Representative provides more technical support. The exact 'support' modalities are not clear in the absence of narrative progress reports, and include technical assistance (e.g. UNFPA consultant drafted the population policy); financial support (printing, meetings); convening (providing platforms for dialogue) and/or normative guidance (participating in technical working groups).

**Stakeholders agree that supportive policies in PNG are necessary, but insufficient to impact on health and social welfare services and outcomes; barriers to policy implementation are not researched or understood.** Supportive policies are yet to translate in stronger health and

<sup>81</sup> This assumption is not part of the evaluation matrix, but is appropriate vis-à-vis UNFPA's role in policy dialogue

community systems at provincial and local level, and increased coverage of sexual and reproductive health services. Barriers are multiple, including lack of dissemination of policies to provincial health authorities<sup>82</sup>. Despite UNFPA's focus on priority provinces, there has been no effort to assess factors supporting or hindering the nexus between national policies and decentralized health system management.

**Assumption #2. Provincial Health Departments (in project provinces) are able to plan, deliver and monitor SRH services**

**Several priority provinces have SRH strategic and operational plans, but these have not been supported by UNFPA.** The evaluation found that the health authorities in Morobe and ARB have developed SRH strategies. These provinces have not received planning support from UNFPA, but from other development partners, including expatriate health planning advisors.

**Despite UNFPA support for health worker training, there is no evidence of increased health worker capacity in family planning or emergency/essential obstetric care.** UNFPA provided financial and technical support to roll out three trainings: 1) the family planning training developed and implemented by MSI with NDOH and 2) the EOC/EMOC training developed and implemented by the Reproductive Health Training Unit (RHTU) with NDOH. For the FP and EOC/EMOC training, UNFPA supports the per diem for trainees, i.e. the counterpart funding that provinces are supposed to contribute to the national training roll out. There is no evidence that the FP/EOC training has impact on health workers capacity or health service quality or scale. Stakeholder mentioned several reasons, including 1) low coverage of training (estimated 200 FP and 225 EOC trainees in 2 years<sup>83</sup>); 2) limited follow up & supervision after the training (the family planning training notably includes on-site refresher and certification); 3) a context of understaffing (in ARB only 50% of positions are filled); and 4) health facilities lack the resources to implement new skills (e.g. no vacuum extractors). Health managers report that with the ageing of the current health workforce, it is more effective to invest in pre-service training than in-service training.

**UNFPA support has strengthened the RHC security/supply system in the northern region; all priority provinces report improved availability of supplies.** The UNFPA RHC supplies program supports level one health facility supply and stock management training. This training is developed by UNFPA and implemented by NDOH, financed by UNFPA. The training is not focused on priority provinces, because training is organized from regional area medical stores for the provinces under their coverage. Stakeholder report success in the Northern region covered by the Lae Area Medical Store (AMS), due to buy-in of the management. In the other region much less progress has been made. Evidence of effectiveness in the northern region is from management information systems: orders for re-stocking increased from 50% to 90% among trained health workers<sup>84</sup>. Further evidence comes from a UNFPA supported health facility survey<sup>85</sup> which found 87% of surveyed health facilities had available seven (including the 2

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<sup>82</sup> pers. comm. Morobe health planning advisor

<sup>83</sup> for details see Annex 5 – UNFPA activities and outputs

<sup>84</sup> Pers. comm. Area Medical Store manager.

<sup>85</sup> UNFPA, 2015, Facility-Based Survey on Reproductive Health Commodity Security in PNG

essential) lifesaving maternal/reproductive health medicines, and 60% of health facilities has at least one stock out on the day of the visit. The survey however did not measure the difference between facilities trained and not trained on supply management. Finally, the 2016 health sector review found a positive trend in medical supplies availability in all PNG including UNFPA priority provinces.

Table 10: Medical supplies availability per priority province<sup>86</sup>

% Months with adequate supplies <sup>87</sup>				
Province	2012	2013	2014	2015
National average	49	53	87	87
ARB	42	49	78	87
Central	35	41	65	86
Enga	65	62	75	88
Morobe	59	62	75	93

**Maternal death surveillance is not operational in PNG or priority provinces.** UNFPA provides support to WHO, the lead agency on promoting a ‘maternal death registration and response’ system, international good practice for improving maternal health services. UNFPA and WHO technical officers undertook several advocacy visits to several provinces, including but not limited to priority provinces. There have not been specific support activities in priority provinces.

**Assumption #3. Comprehensive, gender-sensitive, high-quality SRH services are in place and accessible in underserved areas with a focus on vulnerable groups in project provinces<sup>88</sup>**

**UNFPA supported the direct delivery of family planning services through Marie Stopes International for one year as a one of activity.** UNFPA fully financed MSI to deliver family planning services. The year-end progress report UNFPA received from Marie Stopes indicated that the activities were carried out in 2013. The targets for service delivery was 2,759 clients and 8,784 CYP, including implant<sup>89</sup>, which was in line with the previous years for the MSI clinic. There are no progress reports available.

**There is no evidence that uptake of EOC & FP services has increased in project provinces.** The 2016 annual health sector review provides no evidence that SRH service uptake has increased in the UNFPA project provinces. The rate of supervised births of health facility (an indicator of health seeking behavior) has not improved nationally, or in the project provinces. The rate is higher in ARB than the national average, but has not improved in the project period. In term of family planning uptake, Morobe performs above national average, but the other priority provinces don’t do better than national average, nor is there in increase in uptake over the

<sup>86</sup>NDOH, 2016, Sector Performance Annual Review 2011-2015

<sup>87</sup> definition: nil stock outs of 8 essential medical supplies, including for family planning (Depo-Provera) and maternal health (ergometrin)

<sup>88</sup> This assumption relates to UNFPA support for direct service delivery. See discussion under relevance

<sup>89</sup> Agreement UNFPA-MSPNG 2013

project period.

Table 11: Maternal health outcome per priority province<sup>90</sup>

% Supervised births at health facility <sup>91</sup>				
Province	2012	2013	2014	2015
National average	44	43	44	37
ARB	70	67	65	62
Central	30	29	31	28
Enga	26	33	28	29
Morobe	30	19	9	25

Table 12: Family planning uptake per priority province<sup>92</sup>

Couple years of protection/1,000 women (15-44) <sup>93</sup>				
Province	2012	2013	2014	2015
National average	70	43	63	66
ARB	70	78	49	37
Central	49	16	47	35
Enga	19	14	21	29
Morobe	80	48	49	70

**UNFPA enabled the availability of implants and female condoms in PNG, but the experience of these new family planning methods has not been evaluated or documented.** Introduction of these methods was not preceded by market or acceptability research. There is anecdotal evidence of popularity of implants among women, but also about resistance from male partners. Several cases are reported of implants being forcefully removed, and of health workers who provide implants only with spousal approval<sup>94</sup>. An earlier report found that female condoms are popular among sex workers, because they provide greater control<sup>95</sup>. The introduction of these new methods provided an opportunity to promote innovation in family planning policies and strategies. Clearly there is a need and opportunity for operational research.

<sup>90</sup>NDOH, 2016, Sector Performance Annual Review 2011-2015

<sup>91</sup> definition: percentage births that occur at hospitals or health centers

<sup>92</sup>NDOH, 2016, Sector Performance Annual Review 2011-2015

<sup>93</sup> definition: the amount of (modern) contraceptives provided to protect one couple for a year. Note: condoms not included.

<sup>94</sup> pers. comm. MSI managers

<sup>95</sup> SCA, 2016, Project Evaluation Poro Sapot Project



Table 13: Contraceptives provided by UNFPA supplies program (in '000)<sup>96</sup>

	MOH				MSI			IPPF	TOTAL
	2013	2014	2015	2016	2014	2015	2016	2016	
Condoms, M				43.2	439.2		388.8	50.4	921.6
Condoms, F		100.0	20.0		38.0	373.0	1.0		196.3
OC					2.2	14.0	10.0		26.2
IUD					4.0	3.7	3.7		11.4
Injectable					10.8	10.7	10.0	12.6	44.1
Implant	166.0	70.0	75.8	81.0	20.0	20.0	21.0	1.0	454.8
Emergency OC					3.6	3.0			6.6

**Assumption #4: Support for innovations resulted in improved national capacity for SRH services.**

**UNFPA did not use support for innovation in service delivery as a strategy to influence policies and strategies for SRHR.** Instead, UNFPA supported SRHR service delivery per se, i.e. to increase coverage of SRHR services, as discussed elsewhere. MISP (the minimum initial service package post emergency) and EOC services are not intended as innovation. Therefore, this assumption is not justified.

- **A MISP protocol exists, but roll out has stalled.** UNFPA co-funded and facilitated two trainings on MISP, organized by IPPF under a contract from the UNFPA Pacific Regional Office. 60 health managers were trained in East New Britain (2015) & NCD (2016)<sup>97</sup>.
- **UNFPA did not undertake an essential obstetric care baseline survey.** WHO is the lead agency for a baseline on EOC services; besides this activity was not meant to innovate.

<sup>96</sup> RHCS reports 2013-2016

<sup>97</sup> source: training report & pers. comm. IPPF

### 4.3 EFFECTIVENESS OF UNFPA ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH INTERVENTIONS

Evaluation question: to what extent has UNFPA support helped to increase the access of young people (including adolescents) to quality sexual and reproductive health (SRH) services and sexuality education?

**Summary of the answer:**

The UNFPA PNG result framework does not have a specific ASRH result area, but contains several ARSH outcomes and outputs. UNFPA participation in joint policy dialogue resulted in a national ARSH policy, but this policy has not yet translated in provincial systems or services. UNFPA support for peer education in university and community has not been evaluated, and there is no evidence that these services increase coverage or quality of ARSH services. Support for comprehensive sexuality education in the education sector is stalled due to lack of counterpart interest. Youth interventions in the context of Bougainville peace-building are popular, but there is no evidence if/how empowerment contributes to sexual or reproductive health outcomes.

**Effectiveness finding #11:** There is progress on national policy development for adolescent sexual and reproductive health, but the review of the national youth policy is postponed.

**Effectiveness finding #12:** There is no progress on operationalization of the national ASRH policy at provincial level<sup>98</sup>

**Effectiveness finding #13:** There is no progress on health and education system strengthening for comprehensive sexuality education in school or youth-friendly health services.

**Effectiveness finding #14:** The effectiveness of the UNFPA supported youth peace initiatives (mock parliament, self-management courses and youth centers) cannot be established. The expected impact is ill defined (ASRH versus empowerment outcome); there is no evaluation planned, and it may be too early to expect impact.

**Effectiveness finding #15:** Effectiveness of the UNFPA supported peer education by UPNG and YWC cannot be established. There are no clear objectives or progress monitoring beyond people trained and reached. Impact on vulnerable youth is unlikely.

**Effectiveness finding #16:** There are significant barriers for young people to access family planning services, including parental and health workers attitudes. Although 50% of the PNG population is younger than 19 and becoming sexually active, they are not targeted for SRH services, nor is there any research on service accessibility.

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<sup>98</sup> See footnote under Assumption #2

Assumptions	Evidence
1. National policies agreed and operationalized that support the ICPD agenda regarding ASRH and rights <sup>99</sup>	•
2. Provincial health and education departments are able and willing to plan, deliver and monitor adolescent SRH & HIV services	<ul style="list-style-type: none"> <li>• Provincial ASRH strategies developed &amp; operational</li> <li>• Provincial school health programs developed &amp; operational</li> <li>• Evidence of increased capacity of health workers/schools to deliver youth friendly health services</li> </ul>
3. Young people's access to sexual and reproductive health services and information, including sexuality education is increased through supported projects in project provinces	<ul style="list-style-type: none"> <li>• Evidence of increased coverage of supported ASRH projects (YWCA, UPNG, DoE)</li> <li>• Evidence of use of SRH/HIV prevention services by young people, in-school and out-of-school (UPNG/UoT/DoE/YWCA)</li> </ul>
4. Youth participation and engagement in issues that affect them has increased	<ul style="list-style-type: none"> <li>• Evidence that youth parliament in Bougainville/provinces increased quality, access and use of youth SRH services</li> </ul>

**Assumption #1: Supportive policy environment for youth friendly services for sexual and reproductive health.**

**UNFPA supported the NDOH to develop the Adolescent SRH strategy.** UNFPA participates in the WHO-led ASRH technical working group, and supported the two advocacy meetings and a training of NDOH managers on ASRH. The department agreed the ASRH policy in 2012, but little training or operationalization has happened since. UNFPA also supports a staff member in ASRH in the NDOH. UNFPA did not commission formative research on barriers to youth friendly health services.

**UNFPA discontinued support for the Department of Education to develop national comprehensive sexuality education curriculum.** A national policy for HIV in the education sector exists since 2005, and UNFPA aimed to support the education sector to develop a sex education program. Despite the development of a teacher-training curriculum in 2012, this initiative was unsuccessful due to limited interest from the DoE. UNFPA discontinued the activity. UNFPA did not commission formative research on barriers to comprehensive sex education.

<sup>99</sup> This assumption is not part of the evaluation matrix, but is appropriate vis-à-vis UNFPA's role in policy dialogue

**Assumption #2: Provincial health and education departments are able and willing to plan, deliver and monitor adolescent SRH & HIV services<sup>100</sup>**

**There is no progress towards provincial ASRH strategies.** The Morobe provincial health authority organized an advocacy meeting on ASRH with 50 young people, but this was without UNFPA support. The evaluation found no evidence of plans and strategies

**No progress towards provincial school health programs.** As mentioned above, the UNFPA support for the DoE was discontinued because of interest and capacity issues. UNFPA tried to replicate the UPNG peer education program in other universities, but was unable to do so due to the decrease in core funding. The evaluation team heard of a personal initiative in ARB by the youth leader (and ex UNFPA staff) to undertake a sexuality education training. This one-off initiative received financial support from UNFPA but was not evaluated or followed up

**Little evidence of increased capacity of health or education workers or to deliver youth friendly health services.** UPNG student welfare department trains 20-30 peer educators per year, with UNFPA funding, to provide interpersonal counseling and group sessions on SRH issues and family planning. The training curriculum may be outdated as it was developed with UNFPA technical assistance in 1997. YWCA trains 40 out-of-school youth peer educators per year with UNFPA funding, but does not provide any follow up training or supervision. Neither program has been evaluated in terms of quality, reach or effectiveness.

**Assumption #3: Young people's access to sexual and reproductive health services and information, including sexuality education is increased through supported projects in project provinces**

**No evidence for increased coverage of UNFPA supported ASRH services.** The UPNG peer education program existed already in the previous UNFPA country program and has continued without expansion or replication. Additional youth friendly services have not been piloted or supported, other than the MSI family planning services, which do service young people, but are not specifically targeting them. In fact, MSI ARB clinic was forced to seek parental approval for contraception due to objection of the Catholic Church to family planning services to minors.

**No evidence of increased use of SRH/HIV services by young people.** National or provincial data on service uptake, disaggregated for age, are not available. UNFPA supported service for young people include the UPNG peer education program that reaches 600 students per year for counseling and roughly 2,000/year through group activities<sup>101</sup>. Coverage of the YWCA out-of-school peer education program is not monitored. The UNFPA supported radio program on SRH issues does not target young people (who tend to listen to commercial radio channels).

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<sup>100</sup> Note: In response to the draft CPE report, this assumption may need to be revised. UNFPA PNG does not perceive operationalization of the national ASRH policy as an objective of the country program, it is therefore inappropriate to include this assumption in the evaluation matrix. (It does however affect the assessment of relevance – because UNFPA should consider adolescent SRH services and strategies as a priority for PNG)

<sup>101</sup> pers. comm.: Director UPNG program

**Assumption #4: Youth participation and engagement in issues that affect them has increased**

**No evidence that youth parliament in Bougainville increased quality, access and use of youth SRH services.** UNFPA supports youth empowerment so that young people can raise issues that affect them, including sexual and reproductive health issues. UNFPA supported two mock youth parliaments in ARB, one through NYDA in 2013, and a second in 2015, with DFAT funding through WVI. The stated objective of youth parliaments is increased young men and women's participation in their communities and local and regional civic affairs. There is no anecdotal or other evidence that young people who participated in the mock parliament increased political attention for ASRH, or that the parliament sessions addressed ASRH issues. Youth representatives mentioned economic and political empowerment as the main positive outcomes.

The self-management clinics supported by UNFPA targeted young adults who are affected by the ARB civil war, with the objective to reduce posttraumatic stress. The objectives of the youth centres that are part of this project supported through the UN peace-building fund are not clear, but they are yet to be established. All stakeholders perceive the self-management training to be very useful for personal development.

In other provinces, overall youth policies or development plans are being developed through the department of community development youth desk and the National Youth Development Authority, a UNFPA counterpart. UNFPA supported this process in Morobe. NYDA also supported establishment of provincial youth councils in ARB (presently defunct<sup>102</sup>) and Enga<sup>103</sup>. These activities have not been evaluated, but the impact on SRH policies or services is not evident.

#### 4.4 EFFECTIVENESS OF THE UNFPA POPULATION AND DEVELOPMENT SUPPORT

Evaluation question: to what extent have population data (demographic statistics, census data, etc.) been effectively produced and taken into account in poverty reduction strategies, policies, and plans and programs?

**Summary of the answer:**

**UNFPA supported policy advocacy and technical assistance to the Planning Department resulted in a revision of the national population policy, which is rights-based. UNFPA technical support to the National Statistics Office resulted in publication of the Census 2011 and two monographs with relevant demographic information for national and provincial planning, yet to be distributed and used. UNFPA currently provides management and technical support for the DHS 2016.**

<sup>102</sup> pers. comm. NYDA act. Director

<sup>103</sup> pers. comm. NYDA act. Director

**Effectiveness finding #17: UNFPA has effectively supported the Planning Department (DNPM) to review and revise the national population policy, including a focus on pro-choice approach to addressing population issues.** Further support is needed for operationalization at national and sub-national level, especially linking to the family planning policy.

**Effectiveness finding #18: UNFPA has effectively supported the National Statistics Office (NSO) to analyze and document the Census 2011, as well as two population monographs.** Further support is needed for dissemination and using the strategic information for policy development, and further support is already requested for the DHS 2016.

**Effectiveness finding #19: The technical assistance provided by UNFPA for the population and development program was appreciated, well defined and effective.** Unlike other UNFPA support modalities for policy development, ‘technical assistance’ is better measurable in terms of effectiveness, cost-effectiveness and attribution.

Assumptions	Evidence
1. UNFPA contributed to the national capacity to integrate population dynamics, reproductive health and gender-equality into development planning at national, sectorial and local levels	<ul style="list-style-type: none"> <li>• National Population Policy agreed and operationalized</li> <li>• 2011 Census data analyzed and used for planning</li> <li>• NRI monographs published and used for planning</li> </ul>
2. Perennial mechanisms for the integration of population variables in national and sectorial development planning are in place	<ul style="list-style-type: none"> <li>• Budget allocation NDPM to integrate population dynamics in development planning</li> <li>• Evidence of capacity NDPM/NSO to undertake, analyze and use census, DHS for planning</li> </ul>

**Assumption #1: UNFPA contributed to the national capacity to integrate population dynamics, reproductive health and gender-equality into development planning at national, sectorial and local levels**

**A National Population Policy is agreed, but yet to be operationalized.** UNFPA provided a technical consultant to support the DNPM to review and revise the National Population Policy. UNFPA financed a special intervention branch in the department to facilitate this process. As a result, the National Population Policy was agreed in 2012, including greater priority for sustainable population growth, as well as greater attention for human rights based approaches to population control. Subsequently, UNFPA set up a parliamentary group on population & development, and hosted annual National Population Days, to increase awareness on population issues. In 2014, the GoPNG published the National Strategy for Responsible Sustainable Development. The population policy is not operationalized (Volume 2, the operational plan is due in 2016) but NDOH developed a Family Planning Policy (see chapter on SRH program).

**The 2011 Census data are analyzed and used for national (but not provincial) planning.** UNFPA provided the same consultant to provide technical assistance to NSO analyze the census data at national and provincial level. The national report is published in 2014, with provincial reports drafted in 2016. The data from the DHS are used to develop the National Sustainable Development Strategy in 2014, although some DNPM staff express doubts about some of the projections<sup>104</sup>. Provincial (health) planners have not yet used the provincial data for planning (family planning) services, because the provincial reports are not yet disseminated.

**Two population monographs are drafted and ready to be published and used for planning.** The same UNFPA consultant supported NSO and NRI to analyze the census data and produce two monographs, one on mortality and one on fertility. A planned monograph on migration was not operationalized, due to lack of interest. The documents are not yet used for planning, as they are not published yet.

**Assumption #2: Perennial mechanisms for the integration of population variables in national and sectorial development planning are in place**

**Mixed evidence of budget allocation of the Department of Planning to integrate population dynamics in development planning.** In 2015, the National Statistician took the initiative to undertake a Demographic and Health Survey (DHS) in 2016. The Government of PNG has allocated one million kina ((USD \$315,000) to the DHS as part of their commitment, which is a sign of ownership. Additional funding for this initiative was secured from DFAT and technical assistance and management support is contracted through UNFPA. The latter is indicative of the appreciation of UNFPA's added value and reputation with the department (and DFAT).

**Some evidence of DNPM/NSO's capacity to undertake, analyze and use census.** NSO staff expressed that the UNFPA technical assistance has increased their capacity to undertake and analyze the next census. Other stakeholders stressed the added value of external, specific technical expertise to assure quality and maintain momentum.

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<sup>104</sup> Pers. Comm. Planning Officer, DNPM

## 4.5 EFFECTIVENESS OF THE UNFPA INTERVENTIONS IN GENDER

Evaluation question: to what extent have the interventions in gender contributed to (i) raising awareness on gender-based violence and (ii) positioning this theme on the national agenda?

### Summary of the answer:

**UNFPA participation in joint UN policy dialogue has resulted in increased awareness and supportive policy development on GBV, but UNFPA's added value cannot be assessed. UNFPA's contribution to joint support for the National Women's Council has not resulted in increased institutional capacity of women's organizations in PNG. There is no evidence that UNFPA support for sectoral responses to GBV (law enforcement and health) results in increased quality or coverage of post GBV services, reporting or prosecution.**

**Effectiveness finding #20: UNFPA (in the UN task team on gender) has contributed to the policy dialogue that resulted in gender supportive policies and increased attention for gender based violence:** Gender and Health Strategy, the Family Protection Act, and the National Strategy to prevent and respond to GBV.

**Effectiveness finding #21: UNFPA (in the UN task team on gender) support has not resulted in building women's machineries in general and capacity strengthening of the National Women's Council in particular;** no lessons have been learned in the process.

**Effectiveness finding #22: The contribution of UNFPA for sectoral responses to gender based violence is hard to establish and probably limited.** The Royal PNG Constabulary (RPNGC) capacity building is largely self-organized. The health sector response is limited to training of Family Support Center staff, without a clear support strategy. Community level responses to GBV are poorly designed and not monitored.

Assumptions	Evidence
The capacity of the National Council of Women to advocate around GBV has improved	<ul style="list-style-type: none"> <li>• NCW strategic and action plan developed, plus 4 provinces</li> <li>• Type and number of advocacy actions and their impact</li> </ul>
Health sector response to gender based violence has improved	<ul style="list-style-type: none"> <li>• Guidance and curriculums on GBV have been updated and used</li> <li>• Evidence of capacity and sensitivity among managers and health workers</li> <li>• Increased coverage &amp; uptake of post GBV services</li> </ul>
Reporting, follow up and prosecution of GBV cases has increased in law enforcement & judiciary system	<ul style="list-style-type: none"> <li>• Number of police officers, lawyers etc. trained</li> <li>• Reporting system in place</li> <li>• Increase in reporting and prosecution of GBV cases</li> </ul>



**Assumption #1: The capacity of the National Council of Women to advocate around GBV (and SRHR) has improved**

**No evidence of NCW strategic and action plan at national or provincial level.** UNFPA supported NCW in 2012 with an organizational assessment and restructuring, and in 2016 the secretariat is still not functional by their own admission, and require another round of reorganization. UNFPA and UNW jointly support this process. The current NCW leadership expressed no clear vision for NCW, other than re-structuring the secretariat. Due to the limited capacity of the secretariat, no activities have been undertaken to strengthen provincial women's councils. Women leaders in AROB and Morobe expressed that they have no relation with NCW.

**NCW have not undertaken impactful advocacy actions.** UNFPA did not liaise with alternative platforms or actors to advocate around GBV or SRHR. Examples of other GBV advocates are male or female policewomen, health workers, lawmakers, journalists, etc. Despite the inaction of NCW, the Department of Community Development and Religion, with support from UNDP, has drafted a national policy for the prevention and response to GBV (in 2016). The role of UNFPA in this policy process is not clear. UNDP and UNW are the lead agencies in GBV policy development and research<sup>105</sup>.

**Assumption #2: The health sector response to gender based violence has improved**

**Guidance and curriculums on GBV services exist and others are being developed.** The Family & Sexual Violence Action Committee (FSVAC), an implementing partner of UNFPA, use an existing training curriculum for counselors at Family Support Centers (these are GBV-survivor counseling centers established by NDOH since 2006 at provincial hospitals, but presently no longer supported as part of the regular health system). A national taskforce is currently developing new guidelines for medical and psychosocial management of GBV victims, including referral mechanisms. UNFPA supports the work of this taskforce and has provided technical and financial support to the development of these guidelines. These guidelines are to be used at FSCs as well as other health facilities where GBV victims present (including emergency departments and health centers), and are not yet finalized.

**There is no evidence that UNFPA supported training has increased capacity and sensitivity among managers and health workers.** UNFPA's strategy to strengthen the health sector response to GBV is to train FSC staff in counseling and reporting. GBV training of front line health workers (e.g. at emergency departments, where the majority of victims present) is under development by NDOH and not yet implemented. FSVAC rolled out a training program for FSC staff in 15 provinces (including 3 priority provinces) but there has been no evaluation of this training program. UNFPA also does not support the establishment or recurrent costs of FSCs in priority provinces (the ARB FSC reports being at the verge of closing because UNICEF support runs out and there is no regular health budget). Provincial health managers interviewed (and community development managers) are committed to address GBV in the health sector, but they need support to develop strategies.

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<sup>105</sup> UNDP, 2013, 'Rapid Assessment of Institutional Readiness to Deliver Gender-Based Violence and HIV Services in Five Provinces of Papua New Guinea'

**Coverage & uptake of post GBV services seems to increase, but there is no reporting system to quantify this.** As more FSC are opening across the country, service uptake will increase because anecdotal evidence suggests that FSC services are always busy. There is no information on service coverage, because FSC do not report as part of the HMIS, and other health facilities do not report separately on GBV cases. In term of service delivery, the FSC in ARB reports that of all clients, 30% are male, and only 25% are GBV related (the rest mental health). The proportion of GBV is higher in other provinces, probably because post-traumatic stress is common in ARB<sup>106</sup>.

**Assumption #3: Reporting, follow up and prosecution of GBV cases has increased in law enforcement & judiciary system.**

**UNFPA supported some police training on GBV, but most training is organized internally by RPNGC. No lawyers are trained.** The Royal PNG Constabulary has established two service desks where victims of GBV can report, the Sexual Offence Squad (for any sexual offence) and the Family & Sexual Violence Unit (for domestic and/or sexual violence). UNFPA supports the training of FSVU staff in counseling and reporting, through FSVAC. FSVAC trained 40 police officers in 2012, unclear is if this was advocacy or practical training on GBV<sup>107</sup>. Since then, the FSVU unit in the RPNGC developed their own training plan, which is partly supported by UNFPA, including training for frontline officers (FSVU desks only exist in provincial centers). FSVU staff interviewed in AROB and Morobe did not receive training from FSVAC. The trainings of FSVAC and RPNGC have not been evaluated. UNFPA planned to train lawyers on GBV, but this activity did not happen.

**No reporting system for GBV reporting and prosecution in place.** In order to monitor progress in reporting and outcomes of GBV cases, FSVAC was supposed to train FSVU staff in reporting. This did not happen. However, a similar training is being rolled out presently by UNDP. Morobe, FSVU staff received training on use tablets for reporting (but they feel too busy for reporting any other way than in the paper register). ARB FSVU staff reported that they had received computers and Xerox machines to improve reporting (but the computers have not been used for the intended purpose).

**Only anecdotal evidence of increased reporting and prosecution of GBV cases.** In the absence of the reporting system, there is no evidence that reporting, let alone prosecution has increased. FSVU staff express that reporting of GBV is increasing, but still the tip of an iceberg, as most rural victims are not able to report due to travel cost<sup>108</sup>. RPNGC coordinator reports that FSVU are registering 15-25 cases per day, and increasing. Of the perpetrators, 65% get an interim protection order, roughly 10% are arrested and less than 5% are prosecuted<sup>109</sup>.

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<sup>106</sup> MSF, 2016, 'return to abuser' – study report on FSC in Port Moresby and Tari

<sup>107</sup> UNDAF progress report 2012

<sup>108</sup> pers. comm. Police officer AROB

<sup>109</sup> pers. comm. FSVU national coordinator

## 4.6 UNFPA COST-EFFECTIVE USE OF RESOURCES, TOOLS AND APPROACHES

Evaluation question: to what extent has UNFPA made good use of its human, financial and technical resources, and has used an appropriate combination of tools and approaches to pursue the achievement of the outcomes defined in the UNFPA country program?

### Summary of the answer:

**UNFPA programmatic efficiency is limited. UNFPA investment in a variety of interventions across 5 UN task teams and with limited interconnections, results in reduced cost-effectiveness, synergy and impact. UNFPA investment in interventions outside of the four priority provinces, combined with limited scale of some interventions (e.g. health systems strengthening), also results in reduced efficiency. Training is expensive in PNG, yet one-off training is the UNFPA capacity building strategy of choice.**

**Efficiency finding #1: UNFPA implements a large amount of activities, but there is little added value between UNFPA programs and activities.** Reasons may include that 1) the unifying result framework and common objectives in the CCPD was not used as a planning tool; 2) program officers collaborate closely with the 5 UN task teams, and there are few opportunities to discuss the overall UNFPA program; and 3) UNFPA successfully developed additional projects to compensate for decreasing core resources. As a consequence, interventions are implemented in isolation without synergy, and implementing partners are not collaborating where they could benefit from this.

**Efficiency finding #2: Several activities are not cost-effective because they are implemented at insufficient scale and/or intensity.** For example, training a fraction of the provincial family planning workforce will not strengthen the health system, however effective the training is for individual trainees. Likewise, one-off capacity building events (self management clinics, peer educator TOT, counseling training FSC) without follow up and supervision are not cost-effective.

**Efficiency finding #3: UNFPA investment in priority provinces was too small for impact, whilst many resources have been diverted outside priority provinces.** Whilst the strategy to prioritize four provinces to strengthen health systems was strategic, UNFPA has not followed this through. UNFPA did not strategize and plan with provincial counterparts how to use population data to improve health systems and service delivery. Instead several programs invested their support to other than priority provinces, e.g. the supplies program, MISIP program, and FSVAC's GBV training roll out.

Assumptions	Evidence
1. The mix of implementation modalities was appropriate and cost-effective to achieve outcomes	<ul style="list-style-type: none"> <li>Evidence of UNFPA cost-saving implementation modalities</li> <li>Evidence of partners' satisfaction with UNFPA support</li> </ul>

**Assumption 1: The mix of implementation modalities was appropriate and cost-effective to achieve outcomes**

**The evidence of cost saving implementation modalities is mixed.** The overall impression is that cost-effectiveness has not been a strong factor in choosing implementation modalities

*Training* is very expensive in PNG and therefore often not cost-effective. Yet organizing and/or co-funding training is the preferred support modality for UNFPA PNG. In view of the high cost of training, UNFPA has not invested in evaluation of the (cost) effectiveness of trainings, and several trainings are designed as one-off events without any follow up, whereas good practice dictates otherwise (e.g. self management training). Other trainings would be more cost-effective (and sustainable) as TOT (e.g. FSVU/FSC training). Finally, for some trainings, more cost-effective alternatives for capacity building exist. The MISP training is designed to train (and retrain) multiple provincial teams, whereas a central rapid response team would be more cost-effective. The exception is the MSI FP training, which is followed by two on-site refreshers and certification.

UNFPA uses *catalytic funding* to leverage impact of existing programs. For example, UNFPA pays per diems for trainees on behalf of the provincial health authorities, to enable participation in training offered by NDOH. Although this is cost-effective, the trade off is that attribution of effectiveness is hard to establish, and limited influence on quality of the training (even though UNFPA staff are usually present at training).

*Support for policy processes* is UNFPA's main modality and mandate. The specific 'policy support' activities and interventions vary, and the CPE was unable to establish the modalities used for each individual policy process, because this is not documented in UNFPA progress reports. Interventions ranged from very expensive interventions to zero-cost interventions, including 1) long term international TA to manage the strategic planning process, undertake the analysis and write the report for NSO & DNPM; 2) international trips for senior decision makers for exposure, training or representation; 3) funding for and organizing World Population Day in PNG; 4) input from UNFPA (with or without UN partners) for guidelines development; 5) sharing international good practice for policies/guidelines, and 6) technical assistance by UNFPA regional office specialist staff. The evaluation could not assess the effectiveness of these approaches, let alone the cost-effectiveness, but it is evident that UNFPA has not evaluated the policy support interventions for cost-effectiveness.

**Government counterparts and implementing partners express satisfaction with UNFPA support, but external observers challenge UNFPA's approach.** Most partners interviewed for the CPE report to be happy with UNFPA support, which is hardly surprising because UNFPA supports means additional resources and opportunities, in a country where there are very few development partners.

Some key informants from UN agencies and in the health sector express challenge the cost-effectiveness of some of UNFPA's interventions, especially the more expensive ones such as sending people to international meetings or exposure visits. Their suggestion to UNFPA was to increase accountability and cost-effectiveness by demanding at least learning objectives and trip

reports. Suggestions included undertaking less activities, at a bigger scale and with more linkages to other interventions (e.g. the FP and EOC/EMOC trainings in priority provinces)

Informants involved in the recent UNDAF evaluation expressed concern about the overall strategic approach of UNFPA (and the UN as a whole). Suggestions included rethinking support for service delivery and focusing support on translating policies into system strengthening at decentralized levels, addressing structural issues. For example, health planners in both Morobe and ARB have developed human resource development strategies, but lack technical and financial support to take these forward.

## 4.7 UNFPA INTERVENTION MECHANISMS AND ACHIEVEMENT OF THE PROGRAM OUTPUTS

The evaluation question is: to what extent did the intervention mechanisms (financing instruments, administrative regulatory framework, staff, timing and procedures) foster or hinder the achievement of the program outputs?

### Summary of the answer:

**There is limited and mixed evidence on operational efficiency of the UNFPA country program. UNFPA has been effective at resource mobilization for the country program, offsetting reduced core funding. UNFPA administrative systems are slow, leading to delays in funds disbursement and program implementation, and reputational damage.**

**Efficiency finding # 4: UNFPA and government administrative systems are slow, resulting in delays and inefficiencies.** UNFPA commonly employs direct management of partners' trainings (i.e. managing payment of per diems and logistics).

Assumptions	Evidence
1. UNFPA internal administrative and financial procedures allow for a smooth execution of the program	<ul style="list-style-type: none"> <li>• UNFPA ability to mobilize sufficient resources</li> <li>• Appropriateness of the UNFPA administrative and financial procedures for implementation</li> <li>• Appropriateness of the IP selection criteria</li> <li>• Constraints to implementation</li> </ul>
2. Beneficiaries of UNFPA support received the financial and technical resources as planned and in a timely manner	<ul style="list-style-type: none"> <li>• Funding disbursement to partners as forecast in AWP</li> </ul>

**Assumption #1: UNFPA internal administrative and financial procedures allow for a smooth execution of the program.**

**UNFPA has been very effective at resource mobilization for the country program, but at the cost of some mission drift.** In a context of reducing UNFPA core resource (from 2.8 m US\$ in 2012 to 1.5 m US\$ in 2016), and a dearth of development partners in PNG, the UNFPA leadership has been effective to maintain and even increased the overall budget. For the largest part this can be attributed to a 10 m A\$ DFAT grant to manage the 2016 DHS. UNFPA has also been successful in mobilizing resource from UNFPA HQ core programs for PNG, for example the Supplies Program and the MISP program. Finally, UNFPA successfully participates in a grant from the UN Peace Building Fund for the ARB youth initiatives. The tradeoff for raising additional resources is dilution of the program focus and mission drift. Whilst the CPE argues that this is the case for the Peace building grant and the MISP program, the DHS 2016 support and RH commodity supply and security activities are closely aligned with the objectives of the country program.

**The findings about UNFPA administrative and financial procedures for implementation are limited and mixed<sup>110</sup>.** Direct management of training is a key support modality for UNFPA PNG. Several UNFPA staff and partners talked about the challenges of getting per diem to training participants, especially in the province. Some partners indicated that trainings have been postponed due to inability to organize per diems on time. First, cash payments are required because UNFPA can only use bank transfers to UNFPA registered vendors. Second, UNFPA and NDOH staff need to travel to the field with cash; and 3) third, requests for payment need to be signed off twice; at provincial level but as well as NDOH, because only NDOH is a registered counterpart (RHTU can pay provinces directly<sup>111</sup>). UNFPA bank transfers have a two-week delay, with additional delays for interbank transfers. It is not clear if the fact that the one UN fund is managed from New York, USA is a reason for delays.

**Selection of UNFPA implementing partners is largely based on historical relations, and selection criteria are not clear.** All UNFPA implementing partners were already partners in the previous (4<sup>th</sup>) country program. The continuation of partnerships, especially with GoPNG counterparts, reflects the fact that the UNFPA program is based on partnership and policy dialogue. The only new partner in the 5<sup>th</sup> Country Program is IPPF. UNFPA provides funding support for setting up an office in Port Moresby. There is no project document or agreement available, and the rationale is not clear.

For some partnerships the rationale for continuation is less clear, because they reflect specific outcomes or deliverables. The CPE found no evidence of agreements or MOUs that specify objectives of partnerships. Some partnerships have continued despite limited evidence of impact, or exploration of alternative partners to deliver the expected outcome. For example, NCW did not deliver as an effective advocacy platform, yet the contract continued although other women's organizations might have been more effective. The partnership with the DoE to develop models for in-school comprehensive sexuality education was terminated, but alternative partnership, e.g. with NGOs or private schools, were not considered.

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<sup>110</sup> The UNFPA finance and admin team was not available for interview during the CPE, because they were engaged in managing a large training, therefore this assessment is biased towards partners' experiences.

<sup>111</sup> pers. comm. RHTU

**UNFPA experiences several constraints to implementation.** UNFPA managers expressed two main constraints to implementation. First poor road infrastructure and expensive air transport (there are no roads to 3 out of 4 provinces) makes any travel expensive. Second, human and organizational capacities are poor in PNG, including poor capacity of community organizations (youth, women, and sex workers, MSM, PLHIV).

**Assumption #2: Beneficiaries of UNFPA support received the financial and technical resources as planned and in a timely manner**

**Analysis of resource mobilization against planned budgets is not possible.** The annual joint work plans for the five task teams include ‘funded’ UNFPA activities (covered by core resources) and ‘unfunded’ activities, which are contingent on additional resource mobilization. UNFPA staff indicated that ‘unfunded’ activities remained largely unfunded and not executed. This could not be triangulated from financial reports, because UNFPA annual expenditure report formats don’t match with annual work plans.

**Funding disbursement to partners is flexible and follows expenditure rate, but may affect overall program cost-effectiveness** Annual expenditure rates versus budget (burn rate) of the UNFPA program is consistently high (over 90%) across the years<sup>112</sup> (see also table X, chapter 3.2.3.). UNFPA allocates resources to partners and programs at the beginning of the year, and re-allocates these mid-year according to burn rate and resource mobilization. Quarterly partners’ meetings are used to discuss progress and burn rate, and some partners expressed that this is a good opportunity to request additional resources for programming, requesting re-allocation from less performing partners. This practice increases allocative efficiency (i.e. ensuring all budget gets spent), but there is a trade off with programmatic efficiency (i.e. the fund might not be spent on the most important or effective interventions). For example, FSVAC received additional fund to scale up training in non-priority provinces, whereas the coverage of training in priority provinces is too low to be impactful.

As mentioned before, partner report common delays in payment, reflecting administrative system constraints in UNFPA and/or NDOH.

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<sup>112</sup> UNFPA PNG annual expenditure reports 2012-2015

## 4.8 SUSTAINABILITY OF UNFPA SUPPORT AND DURABILITY OF EFFECTS

Evaluation question: to what extent has UNFPA been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to ensure ownership and the durability of effects?

**Summary of the answer:**

**UNFPA support has contributed to a supportive SRHR policy environment in PNG, which should last for the next several years. In the four priority provinces, UNFPA support has not resulted in sustainable institutions (women's or youth councils) or systems (in health, education or law enforcement sectors). Services (e.g. peer education, new contraceptive options) are not sustainable because they depend on external funding, and are not designed for handover.**

**Sustainability finding #1: UNFPA support for policy development has resulted in supportive public policies that can be used in the medium term future for strengthening systems and improving local SRH service delivery.** Although operationalization of the population, health other policies is recognized as a challenge, the policies themselves provide an opportunity for future work.

**Sustainability finding #2: UNFPA support has not yet resulted in sustainable systems and capacities at provincial level.** Support for training of health workers has been too limited in scale, to strengthen health systems sustainably. UNFPA targeted insufficiently on priority provinces to result in sustainable capacities there, notably provincial health authorities did not receive support for SRH service planning and management

**Sustainability finding #3: Service delivery that relies on UNFPA funding is not sustainable.** This applies especially to the self-management clinics and youth centers in ARB, and peer outreach for students and out-of-school youth. The MSI family planning services once funded by UNFPA are presently supported with alternative funding.



Assumptions	Evidence
1. National strategies and policies developed with UNFPA support are implemented	<ul style="list-style-type: none"> <li>• Functional national strategies for RH commodity security, MISP, adolescent health, national population policy</li> <li>• Functional provincial strategies for SRH, Adolescent Health, HIV/SRH peer education in and out of school,</li> <li>• GBV training and reporting systems are functional in health and law enforcement sectors.</li> <li>• NSO plan for analysis &amp; dissemination of the next DHS/census</li> </ul>
2. Institutions supported by UNFPA programs are integrated in the GoPNG structure	<ul style="list-style-type: none"> <li>• National (&amp; provincial) Women's' Councils functional</li> <li>• Youth parliament functional in 4 provinces/AROB</li> </ul>
3. Innovations and service models supported by UNFPA are adopted by counterpart departments	<ul style="list-style-type: none"> <li>• MSI family planning service models adopted by NDOH</li> </ul>

**Assumption #1: National strategies and policies developed with UNFPA support are implemented.**

**National strategies for population and reproductive health are agreed, but largely not yet operationalized.** UNFPA supported the development of several policies (see effectiveness), and these policies are sustainable in the sense that they last until they expire. Stakeholders generally agree that in PNG, there is no shortage of supportive policies, but that implementation is a challenge.

The UNFPA Supplies program has not yet resulted in a sustainable national system for (reproductive) health commodities. The UNFPA support includes human resources at the NDOH, training for health facility staff, and emergency supplies of family planning commodities. The capacity of the Morobe Area Medical Store is strong, but sustainability entirely depends on the personal leadership of the manager. Capacity at the health facilities is reasonably sustainable, because local systems have been supported. The capacity at NDOH is doubtful, because it depends on the transfer of skills by the UNFPA supported staff member.

The UNFPA program for emergency reproductive health services in humanitarian settings did not build a sustainable national program. UNFPA supported two trainings in the last five years through IPPF; there has been no follow up since the TOT training in all 4 regions in 2011.

**Despite provincial advocacy meetings, there is not evidence of functional population or SRH provincial strategies in priority provinces.** UNFPA undertook specific province level advocacy interventions to roll out the Family planning and Population policies, and National Youth policy. UNFPA supported provincial awareness meeting on family planning and population issues in

Morobe (through FSVAC) and AROB, but there was little follow up and there is no evidence that these provincial governments used population data for localized population or family planning policies. NYDA reported that three provinces developed a youth policy, but it is not clear what the role of NYDA or UNFPA was, and if these provincial strategies relate to ASRH.

**There is mixed sustainability evidence on GBV training and reporting systems in health and law enforcement sectors.** The reporting systems for GBV survivor management, referral and follow up have not been developed as planned. The sustainability of services for GBV in the health sector is reasonably secure (although FSC are not sustainable, other health facilities will still see GBV cases). In the law enforcement sector, the sustainability of FSVU and SOS desks seems secure, as these are supported by the RPNGC core budget. The training of FSC counselors by FSVAC depends on UNFPA funding and is not sustainable, especially not in provinces that are not UNFPA priority provinces. The training for FSVU staff is no longer (fully) financed by UNFPA, and is therefore sustainable.

**NSO commitment to analyze and disseminate the next DHS is evident.** The senior political leadership of PNG is committed to population and development, as indicated in the national development strategy. Key informants expect sustainable development and population to be a core principle for the next development plan and UNDAF. The national statistician requested external support for the DHS 2016, which is a sign of sustained interest. Included in this plan is analysis and dissemination of the results.

**Assumption #2: Institutions supported by UNFPA programs are integrated in the GoPNG structure**

**The National Women's Council is sustainable, but not functional.** NCW is established by Act of Parliament (2013) and represents a huge network of women from the grassroots to national level. It is a parastatal organization, under the umbrella of the Department of Community Development & Religion. NCW just received a large grant from the EU. Yet, despite UNFPA's (and UNW) support, the secretariat is largely non-functional, and lacks leadership and a strategy (see effectiveness).

**The mock youth parliaments were useful in ARB, but they are not meant to be sustainable.** The Bougainville mock youth parliaments have resulted in several participants to take up a political career; one has been elected MP. The aim of the youth parliaments is to increase youth involvement in social and political life, specifically in ARB where there is a 'lost generation' of young people, undereducated, under-skilled and traumatized due to the civil war.

**Assumption #3: Innovations and service models supported by UNFPA are adopted by counterpart departments**

**UNFPA supported innovative approaches to family planning, but these are not sustainable.** UNFPA supported NDOH and MSI to introduce the female condom and implants as family planning (and STI prevention) methods. UNFPA provides the commodities to MSI, IPPF and

NDOH through the Supplies program, and co-finances MSI training for family planning workers on implant techniques. NDOH has adopted implants into the range of contraceptive methods, although the reporting formats for FP clinics are not yet adjusted, therefore use cannot be monitored. Regarding female condom, the supply has decreased since the introduction, and stopped altogether through the government system. There is no evidence of any promotion campaign of family planning, let alone specific demand creation for implants and female condom. There has been no evaluation of acceptance or barriers, despite some anecdotal evidence that women (sex workers) prone to rape appreciate female condom, and that implants are popular with women but unpopular with their spouses.

#### 4.9 UNFPA COUNTRY OFFICE CONTRIBUTION TO UNCT COORDINATION MECHANISMS

Evaluation question: to what extent has the UNFPA country office contributed to the functioning and consolidation of UNCT coordination mechanism?

**Summary of the answer:**

**PNG is a “Delivering as One” country, and UNFPA actively contributes to 5 of 8 joint UN task teams, to the UNDAF results, and to UN coordination platforms.**

**UN Contribution finding #1: PNG has been a “one UN” country since 2006, and UNFPA PNG actively contributes in 5 of the 8 joint UN task teams (and to as many UNDAF results)**

Assumptions	Evidence
1. The UNFPA country office actively contributes to UNCT task teams and joint work plans.	<ul style="list-style-type: none"> <li>• Evidence of active participation in UN working groups</li> <li>• Evidence of a leading role by UNFPA in task teams and/or joint initiatives that correspond to its mandate areas</li> <li>• Evidence of exchanges of information between UN agencies</li> <li>• Evidence of joint programming &amp; planning</li> <li>• Evidence of joint implementation of programs</li> </ul>

**Assumption #1. The UNFPA country office actively contributes to UNCT task teams and joint work plans.**

**UNFPA staff actively participate in UN working groups, but UNFPA is not the lead agency in any of the task teams.** The Country Representative is active in the UN Country Team. The International Program Coordinator co-chairs the UN Program Coordinating Committee (the apex body for the 8 task teams). UNFPA program officers participate in 5 joint UN task teams. See also chapter 3.1

Table 14: UN task teams and UNFPA membership

UN Thematic task team	Lead* and members agencies
MDGs & Population	UNDP, <b>UNFPA</b> , UNICEF, WHO
Peace-building Bougainville	UNDP, OCHA, OHCHR, UNESCO, <b>UNFPA</b> , UNHCR, UNICEF, UNW, WHO
Gender Task Team	UNW, OHCHR, UNAIDS, UNDP, <b>UNFPA</b> , UNHCR, UNICEF, WHO
HIV/AIDS	UNAIDS, UNDP, UNESCO, <b>UNFPA</b> , UNICEF, UNODC, UNW, WHO
Health	WHO, UNICEF, <b>UNFPA</b>

\*the lead agency is mentioned first

**There is ample evidence of information exchange between UN agencies.** Being a One UN country, joint UN task teams meet regularly. Besides most relevant UN agencies are housed in on UN office, with UNAIDS and UNW offices nearby. Therefore informal information exchange is also easy. As argued earlier, the downside of the successful joint UN coordination is that there is limited information exchange and synergy *within* the UNFPA country team.

**There is ample evidence of joint UN programming, planning and implementation.** All UNFPA activities are planned through annual joint work plans for each of the five UN task teams. Many UNFPA activities are joint activities with other UN agencies, especially the more upstream work of policy development and technical support for guideline development<sup>113</sup>:

Table 15: Examples of joint implementation

UNFPA area of work	UN partners for implementation
<b>Sexual and reproductive health &amp; rights</b>	
NDOH policy dialogue on FP/SRHR	UNFPA/WHO
TA for maternal death audit	WHO/ UNFPA
TA for HIV peer education sex workers	UNFPA/ UNAIDS /UNICEF
Advocacy for sex work decriminalization	UNAIDS/UNFPA/UNW
MDG Radio Advocacy campaign	UNFPA/ UNDP/ UNICEF
<b>Adolescents and youth</b>	
Policy dialogue Youth Policy	UNFPA/ UNDP
Policy dialogue ASRH with NDOH	UNFPA/WHO/UNICEF
TA comprehensive sex education schools	UNFPA/UNAIDS/UNICEF
Youth services for peace in Bougainville	UNFPA/ UNDP
<b>Gender and women's empowerment</b>	
Support for women's machineries	UNFPA/ UNW
Health sector response to GBV	UNFPA/WHO/UNICEF
Law enforcement response to GBV	UNFPA/ UNDP

<sup>113</sup> See Annex 5, UNFPA projects and outputs

Table 16: Examples of joint UN programming

UNFPA area of work	UN partners for programming
Sexual and reproductive health & rights	WHO/UNAIDS/UNICEF
Adolescents and youth	WHO/UNAIDS/UNDP/UNICEF
Population & Development	WHO/UNDP
Gender and women's empowerment	WHO/ UNDP/UNICEF/UNW

#### 4.10 UNFPA ADDED VALUE TO OTHER UN AGENCIES

The evaluation question is: what are the main UNFPA added value and comparative strengths in the country – particularly in comparison to other UN Agencies as perceived by national stakeholders? Are these strengths a result of UNFPA corporate features or are they specific to the CO features?

**Summary of the answer:**

**The comparative advantage of UNFPA PNG is the area of population and development. In PNG, UNDP and UNW have a comparative advantage in the area of GBV. WHO is leading on health policy and systems strengthening, including ARSH, but perceives a complementary role for UNFPA in the area of capacity building.**

**Added value finding #1: UNFPA has comparative advantage in the area of population and plays that role well.**

**Added value finding #2: WHO perceives added value in UNFPA co-financing health worker training, to complement WHO's normative work.**

**Added value finding #3: The area of gender based violence space is crowded: however UNFPA has a comparative advantage in the health sector**

Assumptions	Evidence
1. UNFPA strategies and interventions in <i>population and development</i> add value to the work of other development partners, especially the UN system	<ul style="list-style-type: none"> <li>• Evidence of the quality of UNFPA TA</li> <li>• Funding from UNFPA relative to other donors</li> <li>• Evidence of appreciation key stakeholders</li> </ul>
2. UNFPA strategies and interventions in <i>SRH and Adolescent SRH</i> add value to the work of other development partners, especially the UN system	<ul style="list-style-type: none"> <li>• Evidence of the quality of UNFPA TA</li> <li>• UNFPA funding relative to other donors</li> <li>• Evidence of appreciation key stakeholders</li> </ul>
3. UNFPA strategies and interventions in <i>gender</i> add value to the work of other development partners, especially the UN system	<ul style="list-style-type: none"> <li>• Evidence of the quality of UNFPA TA</li> <li>• Funding from UNFPA relative to other donors</li> <li>• Evidence of appreciation key stakeholders</li> </ul>

**Assumption #1. UNFPA strategies and interventions in population and development add value to the work of other development partners, especially the UN system**

**The quality of UNFPA TA to for population and development is high.** The population policy is written by a UNFPA consultant who has extensive experience in PNG, and well respected by government counterparts.

Table 17: Allocation of UNFPA resources to program areas

Partner	Program area	Total allocation 2012-2016 <sup>114</sup>	% allocation 2012-2016
NSO	pop & dev.	4.018.733	44
NDOH	SRH/ASRH	1.805.917	20
DNPM	pop & dev.	699.512	8
INA	gender	662.504	7
NYC	ASRH	374.726	4
DOE	ASRH	371.200	4
UPNG	ASRH	356.800	4
YWCA	SRH/ASRH	335.000	4
NCW	gender	281.000	3
PMC	pop & dev.	210.088	2
NACS	SRH/ASRH	-	0

<sup>114</sup> see table in chapter 2.2, including assumptions underlying estimates

total	9.115.480
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**UNFPA resources for population and development comprise over 50% of the UNFPA budget.**

Until 2016, the resource allocation (and probably expenditure) for DNPM was the largest proportion of the UNFPA budget after the NDOH. With the DHS 2016 grant, resource allocation for population and development is almost half the total UNFPA budget. UNFPA is largely working alone on population data with DNPM and NSO, and the main funding source for population and development work is DFAT.

**Stakeholders appreciate UNFPA support for population and development.** Government, DFAT and UN system partners agree that population and development is the comparative advantage of UNFPA, especially in PNG where there is demand for support in that space.

**Assumption # 2: UNFPA strategies and interventions in SRH and Adolescent SRH add value to the work of other development partners, especially the UN system.**

**The quality of UNFPA technical assistance is hard to assess.** Most UNFPA technical assistance is provided at upstream level in multi-partner technical platforms for policy or technical guidelines development. The specific technical assistance provided by UNFPA in such groups cannot be determined on the basis of written documentation. Many key informants mention the input of UNFPA staff Dr. Hiawalyar as a resource person. UNFPA regional office staff visits to PNG reportedly happen average twice three times per year, some of these visits are related to technical assistance, but the evaluation team did not have access to documentation of such TA visits. UNAIDS appreciates the UNFPA regional office support for the joint advocacy on legal reform for sex work and homosexuality, and for UNFPA's input in the guideline development for peer education. UNFPA Headquarters and regional offices produce normative guidance, but the CPE did not find evidence of such UNFPA guidance.

**UNFPA resource allocation to SRHR is roughly 36%, which is large in the UN system but small compared to DFAT.** Several other UN agencies in the area of health services, including WHO and UNICEF. DFAT and GFATM are large donors for the health sector, including systems strengthening, health worker training (RHTU) and service delivery (HIV).

**Stakeholders appreciate UNFPAs role and comparative advantage in family planning.** WHO particularly appreciates UNFPA's role in family planning innovation (introduction of implant) and potential to (co)finance health worker training, to complement WHO's normative guidance.

**Assumption #3: UNFPA strategies and interventions in gender add value to the work of other development partners, especially the UN system**

**The quality of UNFPA technical assistance on gender is hard to assess.** UNFPA technical assistance on gender equality and gender-based violence is in the area of policy development (gender and health, GBV response). Technical guidance for the FSC and FSVU training programs is subcontracted to FSVAC. The UNFPA specific contribution in the policy development working groups is not clear, either from the country office or the regional UNFPA staff who reportedly

visited PNG twice.

**UNFPA funding for gender activities is 10% of the budget, which is less than UN partners and other donors.** The larger part of UNFPA funding is the grant to FSVAC to undertake training on GBV and family support services. UNFPA only funds training; others finance the service delivery by FSVU and FSC to GBV survivors. UNDP's budget for GBV programming is reportedly larger than UNFPA's budget.

**Stakeholders consider UNFPA's comparative advantage to work on the health sector response to GBV, not the law enforcement response.** UNDP and UNW also work with law enforcement on prevention and response to GBV.

## 5. CONCLUSIONS

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The main conclusions of the CPE all strategic, as they address strategic positioning issues, organizational issues of strategic relevance and other aspects that have repercussions and implications on the country office strategic response in PNG. Programmatic conclusions are not provided: issues regarding implementation of individual interventions are discussed in chapter 4 and adequately reflected in Chapter 6 (Recommendations). Conclusions are presented in order of importance.

### 5.1 STRATEGIC CONCLUSIONS

**Conclusion #1: UNFPA has contributed to development of supportive policies for population and SRH, but provincial authorities need and demand support to operationalize these supportive policies and strengthen systems, strategies and services for SRH to improve health outcomes.**

**Origin:** Evaluation question 1, 2 to 5

**Evaluation criteria:** effectiveness & relevance

**Associated recommendations:** 1, 2 & 3

**UNFPA's support for the population policy has been relevant and effective;** policy dialogue resulted in political support for pro-choice population control and family planning. UNFPA technical assistance has supported the GoPNG to make good progress in the area of population and development, especially in policy development and availability of strategic information. UNFPA technical advisors have supported the development of the National Population Policy, analysis of the census 2011 and development of population monographs. UNFPA has contributed to supportive SRHR policy development. Policy dialogue and support from UNFPA with WHO and UNICEF have resulted in a series of supportive policies and greater awareness from national decision makers. UNFPA support has contributed to gender-supportive health



policies. UNFPA with WHO and UNICEF supported the development of the gender and health policy, which remains to be implemented at provincial and lower level. UNFPA with UNDP and UN Women supported the development of a national policy to prevent and respond to gender based violence, which is yet to be implemented.

**The supportive policy environment for population, development and SRHR is sustainable in the medium term.** The positive change in policy environment will last until the policies expire and/or the momentum is lost, therefore it is important to capitalize on the recent policy advances.

**At provincial level, health and social welfare managers face multiple barriers to strengthen systems and expand quality and coverage of SRH and family planning services.** Health authorities need and demand support for planning and management of RSH services. On the demand side male attitudes, religion and culture hamper uptake for women and girls. UNFPA is in a good position to support national and provincial health authorities to address these barriers, and capitalize on the recent policy advances

**Support for provincial system strengthening requires targeting intensive capacity building to a limited number of provinces.** Despite having four priority provinces, current UNFPA capacity building is too limited to meaningfully impact SRH services and capacities. Selection of UNFPA priority provinces is not based on systematic assessment of needs and opportunities.

**UNFPA support has contributed to increased capacity to respond to gender based violence in the health sector and non-health sectors.** UNFPA supported the health sector through training for several Family Support Centers at provincial hospitals, the effectiveness of which needs to be evaluated. UNFPA, UNDP & UN Women supported the RPNGC through training of Family and Sexual Violence Unit personnel. UNFPA's support for health systems (roll out of health worker training, supply of RHC commodities, demand generation through radio shows and family planning service delivery) has not resulted in increased health system capacity in the UNFPA priority provinces.

**Conclusion #2: Adolescents are a priority and an opportunity for increasing sexual and reproductive health, and sustainable population growth in PNG, yet the PNG country program does not have a specific result area for ARSH.**

**Origin: Evaluation question 1 & 3**

**Evaluation criteria: effectiveness & relevance**

**Associated recommendations: 1, 2 & 3**

**Support for adolescent reproductive and sexual health is highly relevant.** 50% of the population is younger than 19 years, and at the verge of becoming sexually active. The GoPNG recognizes both the threats and opportunities this demographic provides for achieving sustainable population growth, but adolescent sexual health services in the health and education sector are largely absent. Support for expanding comprehensive sexuality education in the school system has failed, and the NDOH has not yet developed strategies for youth friendly health services.

**UNFPA support has contributed to increased awareness about importance of young people in population issues and their reproductive and sexual health needs.** UNFPA with WHO, UNAIDS and UNICEF have supported development of the Adolescent and Youth Health Policy. UNFPA's support for adolescent friendly family planning services, comprehensive sexuality education and youth involvement is highly relevant but limited compared to the need. UNFPA supported peer education for students and out-of-school youth is very limited in scale, and the models have not been evaluated, documented and shared for replication. It appears that the supported peer education models are not targeting the most vulnerable youth effectively.

**Conclusion #3: The UNFPA PNG program does not have an “evaluation culture”: most interventions are not based on formative research, and their objectives are poorly articulated or tracked. This threatens the relevance and effectiveness of the whole program.**

**Origin:** Evaluation question 1, 2 to 5.

**Evaluation criteria:** effectiveness & relevance

**Associated recommendations:** 1 & 2

**UNFPA activities and initiatives under the UNDAF<sup>115</sup> contribute to a joint result and output, but have no stated objectives,** indicators for success and means of verification. As a result, UNFPA reports on outputs (e.g. number of trainings) to the task team, and on expenditure internally, and are deemed effective if both are on track. UNFPA has not planned or commissioned research, formative or evaluative, to generate evidence for programming<sup>116</sup>. Some projects (for example the radio program Tokstret) are implemented for 5 years without specific objective or being evaluated. As a result, important opportunities for learning lessons have been missed, e.g. acceptability of new contraceptive (female condom, implants); barriers to family planning uptake; assessment of adolescent SRH needs and issues; effectiveness of peer education approaches; effectiveness of mass media, etc.

**Although justification of the UNFPA program activities makes intuitive sense, a needs assessment for the overall program and individual activities is lacking.** The CCPD summarizes and refers to the UN common country assessment, but this falls short of a full situation analysis and problem analysis in the area of sexual and reproductive health. The 2014 situation analysis in the context of the RHC supplies program covered broad supply and demand issues, but was never acted upon.

**Conclusion #4: Whilst the reduction in core resources provided an opportunity for UNFPA PNG to consolidate the country program and increase synergy & cost-effectiveness, resource mobilization resulted in multiple, unrelated interventions of limited scale and reduced synergy within the program.**

<sup>115</sup> A minority of activities that are funded separately tend to have a project document with a result framework

<sup>116</sup> A notable exception is the RHC supplies program, which commissioned a situation analysis (2015) and effectiveness evaluation (2016) but the results are not disseminated or used for programming.

**Origin: Evaluation question 1, 2 to 5 & 6.**

**Evaluation criteria: efficiency, relevance & effectiveness**

**Associated recommendations: 2**

**UNFPA's expansion resulted in a range of diverse activities and projects with variable added value to the overall UNFPA program purpose, thus affecting (cost) effectiveness.** Annual core budget from UNPFA was gradually reduced by 50% over the period 2012-2016, which led the UNFPA country office to mobilize non-core resources through additional programming<sup>117</sup>, rather than consolidation. The absence of a unifying intervention logic is one possible explanation for the failure to align and harmonize UNFPA programs and sub-activities. Another reason for limited synergy is that UNFPA activities relate primarily to the five joint UNDAF task team work plans and objectives, therefore responsible UNFPA staff focus logically on synergies in their task team, rather than within the UNFPA country program. Further challenges to overall focus and cost-effectiveness are 1) investment in activities outside UNFPA priority provinces<sup>118</sup>, and 2) investment in service delivery instead of upstream health systems strengthening or policy work.

**UNFPA support for off trainings is not a cost(effective) strategy for SRH system strengthening.** Implementation costs in PNG are high, especially for trainings (average US\$ 10,000/training). Besides, most UNFPA supported trainings remain to be evaluated on reaching capacity building objectives. There are several examples of UNFPA reducing the high cost of training (e.g. co-funding FP/EOC training), or increasing the effectiveness of training (e.g. in-service follow up & supervision post FP training). But most interventions rely heavily on the roll out of one-off trainings, mostly with limited follow up, training-of-trainers, or delegation to provincial partners. Besides, transaction cost of UNFPA direct management of training logistics appears to be high compared to other organizations. UNFPA organizes training on behalf of several partners, in order to ensure accountability. The trade off is that UNFPA regulations are used, over and above GoPNG rules (in the case of health sector trainings). This strategy results in frequent delays, cancellation of scheduled trainings and additional cost of UNFPA administrative staff travelling to each training.

**UNFPA has a comparative advantage though technical expertise on sexual and reproductive health, and has an opportunity to increase focus and scale.** Compared to WHO and UNICEF, who also support the health sector, UNFPA has a comparative advantage to focus on family planning service quality, accessibility, demand creation and uptake, including research. Compared to UNW and UNDP, who are lead partners on GBV, UNFPA has a comparative advantage to support prevention and response in the health sector.

**Discontinuation of service delivery would be a strategy to increase focus and cost-effectiveness.** UNFPA support for direct service delivery (e.g. family planning, peer education, and self management training) is neither sustainable nor in line with UNFPA guidance. PNG is categorized as an 'orange' (middle income) country, which means UNFPA PNG needs to focus on upstream policy and normative work, and leave service delivery to others. Currently supported services do not contribute to policy dialogue on SRH, e.g. through piloting innovations. Besides,

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<sup>117</sup> For example peace-building activities in Bougainville, UNFPA Supplies and MISP programs, and DHS 2016 grant.

<sup>118</sup> For example health facility supply chain trainings, training of Family Support Centers

services with UNFPA are not likely to be sustained, unless implementing partners access alternative funding (as happened with Marie Stopes).

**Youth programming in ARB support peace-building outcomes, but does not add value to UNFPA's SRH mandate.** The self-management trainings for traumatized youth, mock youth parliaments, and youth centers result in personal, economic and social development. These activities are part of a broader joint UN program to support peace in AROB. There is no link with UNFPA's CO overall SRH objectives.

**Conclusion #5: UNFPA adds value to the joint UN response in PNG, but UNFPA's CPE guidance is not suitable to evaluate UNFPA's contribution to joint UN programming**

**Origin:** Evaluation questions 3, 9 & 10

**Evaluation criteria:** added value and effectiveness

**Associated recommendations:** 4

**UNFPA PNG is committed to 'delivering as one' and contributes effectively to the UNDAF financially, technically and organizationally.** UNFPA participates in five of the eight UNDAF result task teams, and co-chairs the overall program steering committee. UNFPA is one of the larger contributors to the overall UNDAF budget, and brings technical expertise on sexual and reproductive health.

**Assessing the effectiveness of UNFPA activities within a joint UN program is impossible and probably not appropriate.** UNFPA designed and implements its work in the context of a joint UN result framework, and five joint work plans. UNFPA M&E systems ignore the UNFPA CCPD result framework, and the country office reports 1) to UN task team on UNDAF outputs; 2) internally on expenditure against budget allocation (burn rate); and 3) to UNFPA HQ on global progress indicators. Assessment of UNFPA-specific progress from the UNDAF progress reports is challenging, because 1) UN agencies are not mentioned individually, and 2) attribution is impossible for joint outputs or activities (e.g. health policy advocacy involving WHO, UNICEF and UNFPA). In addition, the recent UNDAF evaluation indicated that M&E for the UNDAF is weak. Finally and importantly, the very rationale of 'delivering as one' is to reduce the transaction costs of individual planning and evaluation, thus the need for UNFPA CPE in the context of UNDAF is questionable.

## 6. RECOMMENDATIONS

The following recommendations reflect the strategic conclusions, and are targeted to the UNFPA country program management (unless mentioned otherwise). The recommendations are meant to support the strategic planning for the 6<sup>th</sup> Country Program, which is about to start. The main recommendations are as follows, each with a set of sub-recommendations. The level of priority and relevant conclusions, are in brackets.

**Recommendation #1: Ensure that the design of the country program and individual interventions are based on formative research and international good practice; develop and use a M&E systems as per corporate guidance, and undertake operational research to document lessons and inform policy dialogue.**

**Priority: High**

**Target Level: Country Office**

**Based on conclusions: 1, 2, & 3**

**Operational implications:**

**UNFPA should undertake formative research to ensure relevance of the next country program, and not rely on the UN Common Country Assessment, because that does not provide the level of detail needed.** Action points recommended are as follows:

1. A comprehensive situation analysis on the barriers and opportunities for SRHR in PNG should inform the next country program. The 2015 situation analysis for the RHC supplies program is a good starting point. If formative research cannot be completed before designing the next country program, it should be included as program activity. Strategic information is needed on the following, to ensure relevance:
  - SWOT analysis of provincial health systems to plan and deliver family planning services
  - Understanding social determinants of family planning uptake in PNG
  - Adolescent sexual and reproductive health needs and behaviors
  - Assessment of abortion and post-abortion services in PNG
  - Exploring sexual and reproductive rights in PNG, including LGBT and women with HIV
2. Similarly, each intervention or activity must be informed by a situation analysis or needs assessment. For new activities formative research should be a requirement, including assessment of baselines for indicators of success. For existing activities and projects, assumptions underlying the design need to be validated.
3. The review and revision of the country program is a good opportunity to review international good practice on some of the activities that are currently supported and likely to continue. UNFPA normative guidance and regional expertise should be engaged for this process. At the very least a review of international experience needs to inform 1) models for youth friendly health services; 2) models for comprehensive sex education; 3) health systems strengthening strategies for family planning services; 4) models for gender based violence services in the health sector, and 5) communication strategies using mass media such as radio. (High priority, conclusion # 8)

**The next country program must have an M&E system as per UNFPA corporate guidance.** The following action points are recommended:

1. The Country Office needs to develop a Theory of Change. The current country program is based on an implicit theory of change. A more explicit theory of change is not only good development practice, it will also help current and new UNFPA staff and partners to appreciate the intervention logic, choice of support activities, and assumptions underlying these.
2. The country office needs to review and revise the result framework for the 6<sup>th</sup> country program, including SMART indicators. The UNDAF result framework aims to monitor progress of the UN as a whole, but does not enable UNFPA (or other agencies) to monitor and evaluate their specific objectives. The 6<sup>th</sup> country program needs a result framework that 1) aligns with UNFPA corporate objectives (the overall goal and 4 program areas); 2) identifies indicators for success that are realistic and measurable; 3) provides baselines for each indicators (unless UNFPA supports research to establish baselines). It is also recommended not to revise the result framework during project implementation, as happened in 2015.
3. Each activity or intervention needs to have documented rationale, objectives and indicators. It is a basic principle of project management that each activity explains the problem to address and specifies objectives, 'SMART' indicators and means of verification. Development of the 6<sup>th</sup> country program is an opportunity to do so for current interventions that lack the above, at the very least for: 1) support for the roll out of MSI and RHTU trainings; 2) support for UPNG & YWCA peer education; 3) support for radio campaign on SRH; and 4) health sector response to GBV.

**The UNFPA country team should monitor and evaluate progress towards UNFPA country program objectives.** The following action points are suggested:

1. Instead of UNFPA program managers reflecting on progress in their respective UN task teams (towards *UNDAF outcomes*), there is a need to establish UNFPA team meetings for all UNFPA staff to reflect jointly on progress towards *UNFPA objectives* as specified in the result framework, for the UNFPA program areas and for specific activities. Project monitoring meetings need to include a discussion of challenges and lessons, especially the crosscutting ones.
2. UNFPA should document, disseminate and store project progress. Currently the UNFPA country office reports to UNDAF on UNDAF outcomes, and to UNFPA HQ (SIS) on corporate outcomes, but not on the country program result framework. It is recommended to at least annually, document progress towards the country program result framework, annexing progress overviews for each of activity, plus lessons learnt and recommendations for the next year's work plan. It is also recommended to store any progress report (for separate activities and for country program) in a central space, so that they are available for management and program evaluations

**The next country program should include operational research, to generate strategic information and evidence for policy development.** A useful UNFPA support modality for SRH policy and services is to provide evidence for decision makers and program planners (as intended through the monographs on population issues). The next UNFPA program could encourage more research; as a stand-alone activity or formative research as part of supported activities.

**Recommendation #2: Increase the strategic focus of the 6<sup>th</sup> country program through prioritizing of strategies, interventions, partner organizations, and priority provinces. Increase the scope and scale of effective interventions, and discontinue interventions without established relevance or effectiveness.**

**Priority: High**

**Target Level: UNFPA PNG Country Office**

**Based on conclusions: 1, 2, & 4**

**Operational implications:**

**In developing the 6<sup>th</sup> country program, UNFPA should increase focus of the design by reducing the total number of support activities and interventions, and considering discontinuation of those without evidence of effectiveness or relevance.** Alternatively UNFPA must include research to establish such evidence (see recommendation # 1). More specifically, the following interventions should be reconsidered:

1. The peace building work in Bougainville (youth parliaments, self management clinics and youth centers) unless research provides evidence that this work directly contributes to improving adolescent sexual and reproductive health (relevance).
2. All service delivery (FP services, peer education for students and out-of-school youth), unless these activities are redesigned as operational research projects providing strategic information for policy development and programming.
3. Support for gender based violence responses in non-health sectors, as this is the comparative advantage of other UN partners. Instead focus on health sector responses, but more broadly.

**To increase impact of the program, UNFPA should continue and expand support activities with established relevance *as well as* effectiveness.** Despite the shortage of evaluative research, the country program evaluation was able to establish the relevance of certain support areas. The 6<sup>th</sup> UNFPA country program can build on the supportive policy environment created in the current country program, but will need to turn policies into stronger systems, and increased quality and uptake of sexual and reproductive health services, before the momentum is lost. Specifically, the following interventions have potential if they are scaled up:

1. Targeted population & development policy support to the GoPNG, as there is an established need and demand for this, especially to support national and local governments to actually use the generated evidence for planning.
2. Targeted family planning work, because this is a comparative advantage of UNFPA vis-à-vis other UN agencies, there is evidence of need and unmet demand for family planning services (and of several barriers to access); and the current scale of UNFPA support for health system strengthening is insufficient for impact.
3. Support for adolescent sexual and reproductive health (ASRH) services, because this large demographic is underserved and has the highest need and demand for (family planning) services; this is a comparative advantage of UNFPA, and current ASRH support (peer education, self management clinics) is not evidence based. UNFPA should reconsider targeting older and educated youth, and undertake formative research to

- establish who the most vulnerable adolescents are. UNFPA also target young people as agents of change, e.g. young health workers, researchers, journalists etc.
4. Support to the health sector response to GBV. The review should not be limited to the FSC role, effectiveness and sustainability, but assess broader opportunities for GBV prevention and management.

**UNFPA should reduce and prioritize the number of counterpart ministries and sectors for the 6<sup>th</sup> country program, to increase efficiency and impact, prioritizing the health and planning departments.** Although SRH requires a multi-sectoral *analysis* of the determinants of health, UNFPA has a comparative advantage and established relations in the departments of health and planning. UNFPA has more limited success in the education and law enforcement sector. UNFPA should expand its support to the health department to provincial and local levels, because there is need and demand for technical assistance in provincial health authorities. UNFPA should consider placing staff in provincial health authorities. (Medium priority, conclusion # 11 & 17)

**In the 6<sup>th</sup> country program, UNFPA needs to increase targeting of technical assistance to decentralized governments (especially health departments) and focus more on priority provinces.** Action points are as follows:

1. UNFPA needs to work closer with local government (provincial and below), because this is where service delivery is planned and managed. UNFPA should avoid working in other than priority provinces, and aim for synergies at provincial level between programs, e.g. family planning, adolescent sexual health, and commodity security.
2. Selection of priority provinces must be reviewed. The evaluation confirms that it is strategic for UNFPA to focus support on a limited number of provinces, in order to effectively strengthen local implementation and systems, document and share lessons. If the current four provinces are maintained in the 6<sup>th</sup> country program, UNFPA should undertake a situation analysis for each of the four provinces to guide support activities. Alternatively, UNFPA can select a new set of provinces for the 6<sup>th</sup> country program, based on clear selection criteria. These criteria should reflect both evidence of need (e.g. health outcomes compared to the national average) and evidence of opportunity (e.g. demand for support from provincial health authorities).

**Recommendation #3: Increase cost-effectiveness, sustainability and impact of the 6<sup>th</sup> country program through review and revision of capacity building approaches, and support for training logistics**

**Priority: High**

**Target Level: UNFPA PNG Country Office**

**Based on conclusions: 1 & 4**

**Operational implications:**

**UNFPA should commission a review and revision of the capacity building approaches, including an evaluation of effectiveness and cost-effectiveness of training small groups of people, versus alternative approaches.** Training in PNG is very costly and the country program



evaluation found limited evidence of effectiveness of current trainings. Action points for the country program are:

1. To develop a capacity building strategy for the entire country program, justifying capacity building modalities.
2. To evaluate the effectiveness and cost of any training undertaken by partners, and explore alternative capacity building strategies, for example FSVAC training for FSC staff.
3. To explore investing in pre-service training of health workers, instead of in-service training.

**UNFPA should evaluate the cost-effectiveness of direct management of training logistics and consider alternative strategies.** The CPE found indications that the UNFPA managed training logistics are inefficient and result in reputational damage. A specific evaluation could assess how UNFPA transaction costs for training compare to other UN organizations, government agencies and non-government organizations (including private sector, church based organizations, etc.).

**Recommendation #4: The corporate guidance for Country Program Evaluations needs to be reviewed and revised for UNFPA country programs that are implemented in 'Delivering as One' countries, so that the tools and methods enable assessment of effectiveness and relative contribution of UNFPA to joint UN programs, and accountability for results.**

**Priority: Medium**

**Target Level: UNFPA Evaluation Office**

**Based on conclusion: 5**

**Operational implications:**

The CPE guidance assumes that UNFPA country programs use a UNFPA result framework (CPD) to guide and monitor their work, whereas the UNDAF prescribes outcomes and indicators for all UN. Second, in DaO countries more than other countries, UNFPA implements joint activities with other UN partners in task teams, thus increasing the challenge to measure attribution. Finally UNFPA country offices in DaO countries document progress jointly per UN task team, rather than per UNFPA corporate program area (or CPD result area), which limits the usefulness of CO progress reports as data source.

## **ANNEX 1 TERMS OF REFERENCE**

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### **COUNTRY PROGRAM EVALUATION OF THE 5TH COUNTRY PROGRAM (2012-2017) UNITED NATIONS POPULATION FUND - PAPUA NEW GUINEA**

#### **1. INTRODUCTION**

UNFPA, the United Nations Population Fund Country Office in Papua New Guinea (PNG) is planning to conduct an independent evaluation of its 5th Country Program of Cooperation with the Government of Papua New Guinea (GoPNG) from 2012-2017. The undertaking of this Country Program Evaluation (CPE) is in line with the UNFPA 2013 Evaluation Policy.

The purpose of the CPE is twofold: (i) it is a learning tool which will serve as a major input for the planning process of the next Country Program cycle; and (ii) it is an accountability tool to measure the delivery of results during the current Country Program cycle. The CPE will be used to inform the next program cycle by generating evidence and lessons learnt based on the assessment of the current Country Program (2012 – 2017) outcomes and processes. The CPE will determine how UNFPA contributed to national development efforts, including its alignment with the Government of PNG's priorities and strategies and how UNFPA's work is shaping the development agenda. The evaluation will assess the efficiency, effectiveness, relevance, and sustainability of the initiatives that have been supported by UNFPA during the program cycle. It will also assess UNFPA's contribution to the United Nations Country Team (UNCT) coordination mechanism and the added value UNFPA brings to the country.

The UNFPA CPE will seek to be independent, credible and useful, and will adhere to the highest possible professional standards in evaluation, including complying with the United Nations Evaluation Group's (UNEG) Evaluation Norms and Standards of Evaluation (Annex 1). The evaluation will be responsive to the needs and priorities of the UN system and GoPNG, and engage the participation of a broad range of stakeholders.

As the results of the CPE will inform the development process of the 6th Country Program cycle in PNG, the main users of the evaluation results will be decision-makers of UNFPA at country office, regional and global level, and the organization's Executive Board. Moreover, counterparts in the Government of PNG and other development partners may be interested to review the evaluation findings and recommendations.

#### **2. CONTEXT**

The largest nation in the Pacific, Papua New Guinea is home to 7.3 million people according to the 2011 National Population and Housing Census. This figure was a 40% increase from the population count captured in the 2000 Census. With 80 percent of the population being subsistence farmers, PNG is also very diverse geographically and culturally, with over 800 ethnic groups and languages.

PNG faces a range of complex development challenges. These include service delivery to a diverse, dispersed and mostly rural population in more than 600 islands; poor accessibility to

basic services in many parts of the country; and high logistical costs and supply chain management issues. About 50 percent of the total land area is mountainous, resulting in many parts of the country being inaccessible by road. In 2012 only 7 per cent of the population had access to the electric grid and reticulated water, and two-fifths of health/sub-health centers and rural health posts had no electricity or essential medical equipment<sup>119</sup>.

One of the main challenges faced by the Government of Papua New Guinea and development partners is the relatively high level of crime and violence contributing to a high cost of security overheads. In addition to these costs, the high rate of crime (including domestic violence), has a long-term social impact - constraining mobility and negatively impacting development interventions. The country has also faced periods of political instability including the 2011-2012 constitutional crisis.

PNG has a high level of decentralization with 22 provinces, 89 districts, 313 Local Level Governments (LLGs) and 6,131 Wards. In May 2012 two new provinces officially came into existence (Hela and Jiwaka), continuing the general trend in PNG towards increased financial devolution to provinces, districts and LLGs. The 2014 National Human Development Report (NHDR) for PNG notes that with the recent trend towards decentralization, 'implementation and service delivery is limited by weak capacity among both line government agencies and the sub-national service providers. This has led to inefficiencies in the public service, including corruption'<sup>119</sup>.

Papua New Guinea has experienced significant changes within the last five years. Buoyed by financial resources generated from the extractive sector, the country recently graduated from a low income to a lower-middle income country status. However, the 2014 National Human Development Report notes that 'there is a widespread perception within the country that the extractive-based form of development has not been inclusive or reached as many Papua New Guineans as it could and should have'. Following the first export of liquefied natural gas to Japan in May 2014, aggregate GDP was expected to rise by 20 to 25% in late 2014 and 2015<sup>120</sup>. The Government passed the two largest annual national budgets in the country's history in 2013 and 2014, peaking at USD 5.4 billion for 2014. Compared to 2012, the budget increased by 87% for the sub-national levels of government, and by 38% for health, education, infrastructure and law and order. By late 2015, the PNG Government was facing a fiscal crisis, hit by lower tax revenues derived primarily from low commodity prices in the international markets, but also due to decreasing economic activity. Several public budget cuts have been made thus placing a strain on the ability of the Government to adequately provide adequate social services such as health and education.

Papua New Guinea's social indicators lie below those of other countries with similar income per capita levels. It is estimated that 40 per cent of the population lives on less than USD 1 per day and that 75 per cent of households depend on subsistence agriculture. Papua New Guinea's Human Development Index (HDI) value for 2014 is 0.505 — placing PNG in the low human development category and positioning it at 158 out of 188 countries and territories. Between

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<sup>119</sup> United Nations Development Program (2015). National Human Development Report: Papua New Guinea

<sup>120</sup> World Bank (2013). Papua New Guinea Economic Briefing: From the last days of the boom to lasting improvements in living standards.

1985 and 2014, Papua New Guinea's HDI value increased from 0.334 to 0.505, an increase of 51.3 percent or an average annual increase of about 1.44 percent<sup>121</sup>.

With considerable allocations of public funds to sub-national levels of government, the risks of increased corruption are significant. The former Task Force Sweep estimated in 2013 that almost 40% of PNG's annual budget was lost to corruption and mismanagement. Advance on the National Anti-Corruption Strategy – including an Independent Commission Against Corruption as well as the Extractive Industry Transparency Initiative – show the Government's intensified stance on transparency and accountability for more equitable development. In spite of continuing pressure from logging companies, PNG still has the third largest tropical forest cover in the world. With payments for Environmental Services schemes, a potential source of sustained income awaits the country. An important challenge for the country will be to adapt to the likely impact of climate change which could result in large parts of the country suffering in future from sea level rise, food insecurity and malaria. Between 1997 and 2010, over 4 million people (over half the population) were affected by natural disasters, with damages estimated at around USD 100 million. The Government has previously mainly focused its policies on climate change mitigation; the last years have seen a shift in strategic thinking on how to deal with adaptation.

### *Sexual and Reproductive Health*

PNG has one of the highest maternal mortality rates in the world at 733 per 100,000 live births<sup>122</sup>. This means that around 1,300 women die as a result of pregnancy-related problems every year. For women in urban settings the risk of dying while giving birth is lower than for those women living in rural areas. Unsupervised deliveries (without a skilled birth attendant) in rural settings are common place and a mother's risk of dying in childbirth is four to eight times higher in rural as compared to urban areas. Of all mothers who deliver in PNG, less than 60% access antenatal services and only 40% of births are supervised by a skilled birth attendant (DHS, 2006). Most rural health facilities are in dire need of repair and provision of supplies. Furthermore, health staff commonly struggle and lack the skills to provide effective treatment and services.

The total fertility rate (TFR) in PNG has remained high, with women in urban areas having a lower TFR than women in rural areas (3.6 and 4.4 respectively). On average, Papua New Guinean women have 4 children. Adolescent birth rate is high at 13%, with teenage girls aged 15–19 having an estimated birth rate of 70 births per 1,000; 22% of 19-year old women have at least one child and 6% have two or more children. The unmet need for family planning is 30% among married women, whilst contraceptive prevalence (using modern methods) is only 32% (DHS, 2006). The prevalence rate of HIV for PNG is the highest in the Pacific at 0.9%.

### *Adolescents and Young People*

Papua New Guinean children and youths are exposed to the highest rate of violence in the East Asia and Pacific Region. Small-scale studies consistently show that a large portion of children is

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<sup>121</sup> United Nations Development Program (2015). PNG: Briefing note for countries on the 2015 Human Development Report

<sup>122</sup> Demographic and Health Survey, 2006

physically, verbally and sexually abused. The formal justice system is not responsive to children's needs in this respect. Less than 20% of child victims of violence have access to the courts, either because of distance or cultural norms such as compensation.

With inadequate school placements, lack of sporting facilities and limited job training opportunities, adolescents and youth are often not fully engaged or able to participate in the development of their community. It is not uncommon for these young people to join gangs and hang out in settlements, looking for something to do, which at times results in them engaging in opportunistic crimes and violence.

Infant mortality is high in PNG. At 75 deaths per 1,000 live births, there has been no real decline over the last 10 years of under-five children dying of preventable causes. Malnutrition remains a significant underlying factor to child morbidity and mortality. Over 48% of children aged five or younger are stunted and about a third of women of childbearing age are anemic.

### *Gender*

Gender equality is a significant challenge in PNG, and systemic violations of women's rights exist throughout the country. In 2014, Papua New Guinea ranked 140 out of 155 countries of the Gender Inequality Index<sup>123</sup>. Women and girls have substantially less access to health care and education services than males. Furthermore, women are vastly under represented at all levels of government (only 3 out of 111 Parliamentarians are women), limiting their power to influence public policy and voice issues.

In rural and urban areas, Papua New Guinean men commonly hold onto their traditional cultural practices, where tribal discipline and power is given to men to have authority over their clan and family members. Men make most of the decisions in the family and control most of the resources, and women are expected to conform to various societal rules and norms, often having their basic rights denied. Girls and women are often viewed as commodities used in exchange for money, gifts and to resolve tribal disputes. This leaves them vulnerable to sexual and gender-based violence, which has become endemic in PNG society. Violence against women and gender-based violence is unacceptably high, with an estimated two out of three women having personally experienced violence<sup>124</sup>.

### *Population and Development*

The population of Papua New Guinea is estimated to reach 13 million people in 2032 at its current annual population growth rate of 3.1%. According to the 2011 Census, Papua New Guinea has a "youth bulge" with 58% of its 7.3 million inhabitants being under the age of 25, one of the highest proportions in the Pacific.

The rapid population growth is putting strain on service delivery and infrastructure. For example, some children cannot go to school as there are insufficient classrooms to cater for

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<sup>123</sup> United Nations Development Program (2014). National Human Development Report: Papua New Guinea

<sup>124</sup> United Nations Population Fund (2014). Population and Development Profiles: Pacific Island Countries. Pacific Sub-Regional Office, p. 58

them. As a result, about 30% of school aged children, or 600,000 children, do not go to school at all, and when they do, many drop out and do not finish even basic primary education.

Whilst population data is available in PNG, it is often not analyzed and under-utilized by policy makers. The National Statistical Office (NSO) conducted the National Census in 2011, but data from the census was not published and released to the public until January 2014 – 3 years later. Many staff at NSO were initially overwhelmed by the sheer volume of data collected and were not able to sort through, collate or analyze the data. With the support of UNFPA, data from survey results were finally keyed into a database and the results were tabulated and published. UNFPA is currently supporting NSO to further analyze the 2011 census data to construct monographs (with appropriate fertility, mortality and migration output tables).

### *Reforms*

Papua New Guinea is undertaking important structural reforms to address social development challenges. In 2014, the Government launched an addendum to its Development Strategic Plan 2010-2030. In line with this, the Government has extended the 2011-2015 Medium Term Development Plan (MTDP) by two years to 2017 to take into account changes to the 2010-2030 Development Strategic Plan and the Government's recently launched National Strategy for Responsible Sustainable Development, and to align with the parliamentary election cycle, which will take place in 2017.

### *UNFPA and the UN Program in Papua New Guinea*

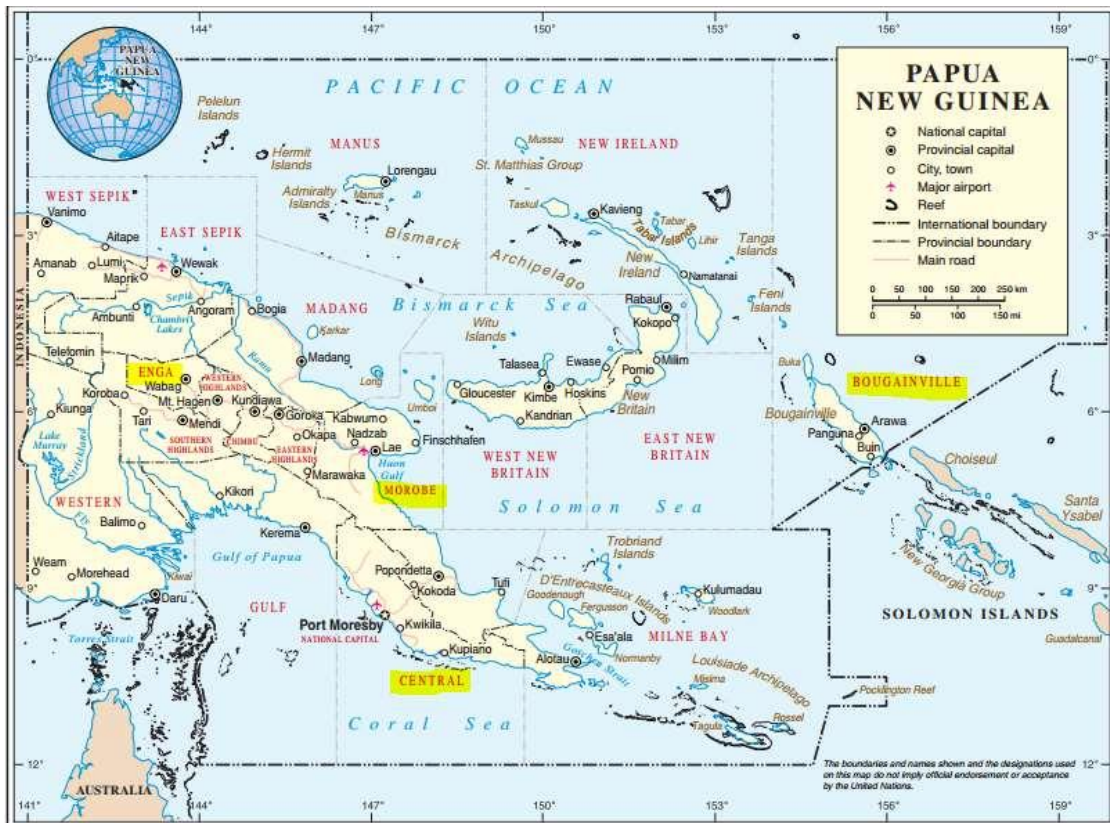
The United Nations Population Fund in Papua New Guinea first opened its office in Port Moresby in 1994. For the last 21 years, UNFPA has worked closely with the PNG Government and civil society to advance issues related to four thematic areas: 1) Sexual and reproductive health and rights; 2) Adolescents and youth; 3) Gender equality and the prevention of gender-based violence; and 4) Population and development.

- Protecting a woman's life when she is giving birth is the central aim of *UNFPA's Sexual and Reproductive Health program*, working within the framework that it takes three interventions to save that life: i) universal access to contraception to avoid unintended pregnancies; ii) access to skilled care during delivery; and iii) rapid access to quality emergency obstetric care. UNFPA supports overall health system strengthening and demand creation for reproductive health, providing technical assistance and capacity building to Government counterparts and civil society organizations.
- Given that young people make up about 60% of the PNG population, UNFPA's work on *Youth and Adolescents* aims to: i) promote youth participation and engagement in issues that affect them; and ii) increase young people's access to sexual and reproductive health services and information, including sexuality education.
- The *Gender program* in UNFPA is focused on i) preventing violence against women and increasing the number of reported and prosecuted cases in PNG; ii) strengthening the National Council of Women's machinery; iii) having guidelines and protocols in place for health workers to care for survivors of GBV; iv) advocacy on issues related to gender. Apart from working with the National Constabulary and Health Department to develop policies and training manuals, UNFPA has also supported the training of health workers and police force to care for survivors of GBV and maintain a database of reported cases.

- UNFPA’s *Population and Development program* is primarily focused on: i) strengthening national capacities to identify and address population and development issues, including data collection and analysis; and ii) the integration of population variables in planning frameworks. The Department of National Planning and Monitoring and the National Statistical Office has been supported by UNFPA to develop the National Planning Policy 2015-2024 and analyze the 2011 Census data, including the upcoming tabulation of the population monographs.

Under UNFPA’s new Business Model (linked to UNFPA’s new Strategic Plan 2014-2017), PNG has been characterized as having a high level of need and a low-to-middle national ability to finance the intervention – and given the color code “orange”. As an “orange colored country”, UNFPA PNG’s expected modes of engagement are: i) advocacy and policy dialogue/advice; ii) capacity development; and iii) knowledge management. To achieve its mandate, UNFPA has formed strong partnerships and works collaboratively with Government Departments, other UN agencies, non-government organizations and bilateral partners in PNG.

UNFPA PNG’s program activities are primarily focused at the national and sub-national level, with main beneficiaries being Government staff from national departments and from provincial and district level departments and agencies. Other UNFPA-targeted beneficiaries include young people and those from civil society organizations (such as faith-based organizations). Adolescents and youths who are in-school (e.g. university students) and out-of-school, have been involved in UNFPA-supported capacity building activities, peer education programs and community outreach activities.



*Figure 1: Map of Papua New Guinea (highlighted are the focus provinces)*

In the 5th Country Program, apart from working at the national level on capacity development and policy advocacy, UNFPA decided to focus its programming efforts in four provinces (Figure 1): Autonomous Region of Bougainville, Central, Enga, and Morobe. These four provinces were selected because they all had high population growth, high GBV rates, low contraceptive use and limited family planning services available.

UNFPA's 5th Country Program is jointly implemented with the United Nations Development Program (UNDP) and the United Nations Children's Fund (UNICEF). The joint Common Country Program Document (CCPD) for Papua New Guinea 2012-2015 was approved by the respective UN Executive Boards in November 2011. [Note: The list of UNFPA PNG projects is outlined in Annex 2 and the CCPD and results framework will be made available to the evaluation team]

UNFPA in PNG operates under the umbrella of the United Nations Development Assistance Framework (UNDAF). Papua New Guinea is a 'self-starter' for the Delivering as One (DaO) approach since 2006. The UNDAF outlines the strategic program framework for the United Nations in Papua New Guinea and it is accompanied by an UNDAF Action Plan that operationalizes the UNDAF. The strategic priorities of the CCPD are in line with those of the UNDAF. Both the UNDAF and Action Plan aim to simplify and harmonize the UN's contribution to national development, ensure alignment with Government of PNG priorities and utilize national systems and procedures for program delivery to reduce transaction costs. Program harmonization and coordination is enhanced through the work of the Task Teams, which is organized into ten thematic groups. Each Task Team has a jointly signed Annual Work Plan with their respective Government counterparts and stakeholders. Most of UNFPA's program activities are implemented by Implementing Partners comprising of various Government agencies and non-governmental organizations, and activities are implemented as agreed through the signed Annual Work Plans.

The current UNDAF and Action Plan were originally planned to be for a four-year period (2012-2015). However, following a GoPNG request, the UN extended the UNDAF for a further two years (from 2015 to 2017). The agreement to extend the UNDAF was in order to align with GoPNG's Medium Term Development Plan 2, which was extended by two years from 2016-2017. UNFPA's 5th Country Program was also approved by the UN Executive Board in 2015 for extension by two years, until 31 December 2017.

The UNDAF was themed 'Supporting PNG to accelerate MDG Achievement' and the following development pillars were identified and agreed upon by the UN and GoPNG as priority outcome areas in support of the GoPNG's MTDP Plan 2011-2015: 1. Governance for Equitable Development; 2. Social Justice, Protection and Gender Equality; 3. Access to Basic Services; and 4. Environment, Climate Change and Disaster Risk Management. The key strategies underpinning the UNDAF are capacity development; the promotion of human rights and the application of a human rights-based approach to programming; the empowerment and strengthening of civil society; promotion of evidence-based monitoring systems; mainstreaming of gender equality and opportunities for women; and fighting HIV and AIDS and other communicable diseases.



### 3. OBJECTIVES AND SCOPE OF THE EVALUATION

#### *Objectives*

The overall objectives of the CPE are:

1. To assess the relevance and contribution of the UNFPA 5th Country Program (2012-2017) to national development results given the country context.
2. To generate a set of clear, forward-looking and actionable recommendations logically linked to the findings and conclusions. These recommendations will include specific guidance on the development of the new Country Program.

Specifically, the CPE aims to:

- a) Provide an independent assessment of the progress of the program towards the expected outputs and outcomes set forth in the results framework of the country program;
- b) Provide an assessment of the country office positioning within the developing community and national partners, in view of its ability to respond to national needs while adding value to the country development results.

#### *Scope of the Evaluation*

The evaluation should be focused on the achievements and challenges faced in Papua New Guinea during the Country Program being evaluated, namely from 2012 to 2017, both at national and sub-national level. As UNFPA primarily focused its program efforts on four focal provinces – Autonomous Region of Bougainville, Central, Enga, and Morobe – it is expected that at sub-national level the evaluation will focus mainly on primary and secondary data from these provinces. Data will be gathered from key stakeholders and beneficiaries.

UNFPA PNG's mode of engagement is also to be evaluated. The evaluation team is to explore how as an "orange country", the UNFPA PNG country office's modes of engagement (advocacy, capacity development and knowledge management) have been delivered and what were the challenges associated with the individual modes of engagement as well as their combination in the country program at national and sub-national levels.

Furthermore, all of UNFPA's program components (Sexual and Reproductive Health, Youth and Adolescents, Gender, and Population) are to be evaluated, using the suggested Evaluation Criteria and Evaluation Questions outlined below.

### 4. EVALUATION CRITERIA AND EVALUATION QUESTIONS

Given the context described above, the UNFPA Country Program Evaluation will focus on program *relevance, effectiveness and efficiency* while also looking at the *sustainability* of interventions moving into the next Country Program cycle. The evaluation will also explore UNFPA's contribution to the *UNCT Coordination* mechanism and its *added value* in Papua New Guinea. The evaluation will examine the following areas:

- A. *Relevance* of the UNFPA Country Program in relation to the issues it was designed to address:
  - a. To what extent is the UNFPA support (i) adapted to the needs of the population; and (ii) in line with the priorities set by the international and national policy frameworks? Do planned interventions adequately reflect the goals stated in the Common Country Program Document (CCPD)?
- B. Assess the *effectiveness* of UNFPA implementation and performance in terms of progress towards agreed Country Program outcomes:
  - a. To what extent have the interventions in gender contributed to (i) raising awareness on gender-based violence and (ii) positioning this theme on the national agenda?
  - b. To what extent have population data (demographic statistics, census data, etc.) been effectively produced and taken into account in poverty reduction strategies, policies, plans and programs?
  - c. To what extent has UNFPA support helped to increase the access of young people (including adolescents) to quality sexual and reproductive health (SRH) services and sexuality education?
- C. Assess the *efficiency* of resources used to implement the Country Program:
  - a. To what extent has UNFPA made good use of its human, financial and technical resources, and has used an appropriate combination of tools and approaches to pursue the achievement of the outcomes defined in the UNFPA country program?
  - b. To what extent did the intervention mechanisms (financing instruments, administrative regulatory framework, staff, timing and procedures) foster or hinder the achievement of the program outputs?
- D. Assess to what extent results achieved and strategies used by UNFPA are *sustainable*:
  - a. To what extent has UNFPA been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to ensure ownership and the durability of effects?
- E. Explore UNFPA's contribution to the *UNCT Coordination* mechanism in the country:
  - a. To what extent has the UNFPA country office contributed to the functioning and consolidation of UNCT coordination mechanism?
- F. Assess what UNFPA's *added value* is to development activities in the country:
  - a. What are the main UNFPA added value and comparative strengths in the country – particularly in comparison to other UN Agencies as perceived by national stakeholders? Are these strengths a result of UNFPA corporate features or are they specific to the CO features?

## 5. APPROACH AND METHODOLOGY

Approach will integrate both gender and human rights perspectives quantitative and qualitative data. These complementary approaches will be deployed to ensure that the evaluation:

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

- c) Utilizes both quantitative and qualitative data collection and analysis methods that can provide credible information about the extent of results and benefits of support for particular groups of stakeholders, especially vulnerable and marginalized groups.

The evaluation will utilize a *theory-based approach*. The evaluation team will be expected to reconstruct and understand the logic behind the program interventions for the period under evaluation from planning documents and represent it in a diagram during the design phase. The UNFPA 5th Country Program in PNG does not have an explicit Theory of Change. The Theory of Change (ToC) reflects the conceptual and programmatic approach taken by UNFPA over the period under evaluation, including the most important implicit assumptions underlying the change pathway. The ToC will include the types of intervention strategies or modes of engagement used in program delivery, the principles/guiding interventions, the elements of the intervention logic, the type and level of expected changes and the external factors that influence and determine the causal links depicted in the theory of change diagram. The ToC will be tested during the field and data collection phase.

The Country Program Evaluation will be carried out in accordance with the revised UNFPA Evaluation Policy. The evaluation will follow the guidance on the *integration of gender equality and human rights principles* in the evaluation focus and process as established in the UNEG Handbook, Integrating Human Rights and Gender Equality in Evaluation - Towards UNEG Guidance.

The evaluation will follow *UNEG Norms and Standards for Evaluation* in the UN system and abide by UNEG Ethical Guidelines and Code of Conduct and any other relevant ethical codes (Annex 1).

#### *Stakeholders' participation*

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

The evaluation team will perform a *stakeholders mapping* in order to identify both UNFPA direct and indirect partners (i.e., partners who do not work directly with UNFPA and yet play a key role in a relevant outcome or thematic area in the national context). These stakeholders may include representatives from the government, civil-society organizations, the private sector, UN organizations, other multilateral organizations, bilateral donors, and most importantly, the beneficiaries of the program. A list of stakeholders will be provided to the evaluation team during the design phase.

#### *Methodology*

The evaluation team will use a *mixed method approach*, including qualitative as well as quantitative data to assess the program's achievements and challenges. The CCPD results framework will guide in particular the assessment of effectiveness and results achieved at output level. The use of multiple methods and the involvement of a variety of stakeholders will

enable data triangulation and will reduce the possible data limitations, limit reliance on single source data and enhance the validity of the findings.

During the design stage, the evaluation team will conduct a *comprehensive desk review* to define the evaluation design, including data collection and analysis methods and required tools. The proposed methodology is to be outlined in the Design Report prepared by the evaluation team with inputs from the Evaluation Reference Group (ERG).

#### *Data Collection*

Data will be collected via *multiple approaches including documentary review, group and individual interviews, focus groups and field visits* as appropriate. In order to avoid duplication of existing data, secondary information will be collected from various sources and analyzed through a comprehensive desk review before the start of the fieldwork. The results will be included in the design report. Data gathering will include monitoring data of the program and its components and annual and other reports of the program, its components and initiatives. Data is to be disaggregated by sex, age and location, where possible. Primary data will be collected making use of key informant semi-structured interviews, focus group discussion, and observations. Data collection methods must be linked to the evaluation criteria and evaluation questions that are included within the scope of the evaluation. The use of an evaluation matrix is recommended in linking these elements together.

The evaluation team is expected to spend *up to 3 weeks in PNG* meeting with stakeholders at the national and sub-national level. The proposed field visit sites and stakeholders to be engaged should be outlined in the Design Report to be submitted by the evaluation team. When choosing sites to visit, the evaluation team should make explicit the reasons for selection and consider the availability of baseline data for these sites. The choice of the locations to visit at sub-national level needs to take into consideration the implementation of UNFPA's program components in those areas and be taken in consultation with the UNFPA Country Office and ERG. Sub-national data gathering will need to cover all the program components of the country program in PNG.

#### *Data Analysis*

The focus of the data analysis process in the evaluation is the identification of evidence. The evaluation team will use a variety of both quantitative and qualitative methods to ensure that the results of the data analysis are credible and evidence-based. The analysis will be made at the level of program outputs and corresponding components and their contribution to outcome level changes. Evaluation questions set within the change pathway of the ToC will be tested to assess where change has taken place. In the process, the evaluation will assess UNFPA's contribution to the change observed over the years. The results of the investigation will test the reconstructed ToC and the assumptions therein.

Judgment will be based on data responding to the indicators set forward in the *Evaluation Matrix*. By triangulating all data from all sources and methods, a comprehensive picture should emerge on the validity of the reconstructed ToC, and UNFPA's contribution to the change observed. The evaluation matrix specifies the evaluation; the particular assumptions to be assessed under each question; the indicators, the "sources of information" (where to look for

information) that will be used to answer the questions; and the methods and tools for data collection that will be applied to retrieve the data. The evaluation matrix must be included in the design report as an annex. During the field phase, the matrix will be used as a reference framework to check that all evaluation questions are being answered. At the end of the field phase, evaluators will use the matrix to verify that enough evidence has been collected to answer all the evaluation questions. The evaluation matrix must be included in the final report as an annex.

#### *Validation mechanisms*

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

#### *Limitations to the methodology*

The evaluation team may face a number of possible limitations and constraints during the data collection and analysis phase. The suggested measures to mitigate these constraints are listed below.

1. *Limitations of Joint Annual Work plans as tracking tools.* The Joint Annual Work Plans (JAWPs) form the basis for tracking program interventions but may be difficult to use to track and consolidate evidence with regard to the intended results for each programmatic area, as some programmatic areas are jointly implemented with other UN Agencies. To mitigate this constraint and to supplement the JAWPs, the team will need to refer to the Country Office Annual Reports (COARs), the Strategic Information System (SIS) Reports, Donor Reports and the Atlas spreadsheets.
2. *Limitations of data collection.* Data collection limitations include a) time constraints (total of three weeks allocated for the field phase); b) high turnover of the staff of the governmental institutions and the NGOs, and movement of beneficiaries; and c) geographic location (e.g. some districts cannot be reached for security reasons or due to limited transport options); and, d) budget constraints to travel. This constraint can be mitigated by the use of secondary data (reports, publications, national plans, regional strategy plans, etc.); through key informant interviews or focus group discussions with groups directly involved in the interventions; and purposive sampling after a comprehensive review of the documents to select the appropriate target groups.
3. *Language constraints.* Whilst most people in urban areas speak English, people in rural areas tend to only speak *Tok Ples* (traditional local language) and *Tok Pisin* (Pidgin English). In order to facilitate communications between English, Tok Ples and Tok Pisin, interpreters may be needed during interviews and focus group discussions.

## 6. EVALUATION PROCESS

The evaluation will be conducted in five phases:

### 1) Preparatory Phase

This phase will include:

- Preparation and approval of the Terms of Reference (TOR).
- Constitution of the reference group for the evaluation (Evaluation Reference Group).
- Selection and hiring of evaluation team.
- A collection of relevant documents available at UNFPA HQ, regional and CO levels regarding the country program for the period being examined.
- A stakeholder mapping exercise – the Evaluation Manager will prepare a mapping of stakeholders relevant to the evaluation (to be given to the evaluation team).

### 2) Design Phase

During this phase, the evaluation team will complete:

- A review of all relevant documents available at UNFPA Headquarters (HQ), regional and CO levels regarding the country program for the period being examined.
- A Stakeholder mapping exercise to select who should participate in the evaluation. This list should include government as well as civil-society and other stakeholders and will indicate the relationships between different sets of stakeholders.
- An analysis of the intervention logic of the program.
- The finalization of the list of evaluation questions.
- The development of a data collection and analysis strategy as well as a concrete work plan for the field phase.

At the end of the design phase, the evaluation team will produce a Design Report, displaying the results of the above-listed steps and tasks. The Design Report Template is outlined in Annex 3.

The evaluation team is also expected to prepare an Evaluation Matrix (see Annex 4) to accompany the Design Report. The Evaluation Matrix displays the core elements of the evaluation: (a) *what* will be evaluated (evaluation criteria, evaluation questions and related issues to be examined – “*assumptions to be assessed*”); (b) *how* to evaluate - the sources of information and methods and tools for data collection. The evaluation team must use the Evaluation Matrix as a:

- Communication tool to inform (in a snapshot) the relevant stakeholders on the core aspects of the evaluation.
- Reference document for developing the agenda (field and analysis stages) and for preparing the structure of interviews, group discussions and focus groups.
- Tool to check the feasibility of the evaluation questions.
- Control tool to verify the extent to which evaluation questions have been answered and to check whether enough evidence has been collected.

### 3) Field Phase

After the design phase, the evaluation team will undertake an in-country mission of up to 3 weeks in duration to collect and analyze the data required in order to answer the evaluation questions, and to get a grounded understanding of the issues at both national and sub-national level. Fieldwork will start with national level stakeholders and a meeting with the ERG after

which visits to selected sub-national areas will be conducted to meet with sub-national and local level stakeholders. The field phase will end at the national level with additional meetings with national level stakeholders as required and a meeting with CO staff and the ERG in order to validate preliminary findings and testing tentative conclusions and/or recommendations.

#### *4) Reporting Phase*

During this phase, the evaluation team will continue the analytical work initiated during the field phase and prepare a first draft of the final evaluation report, taking into account comments made by the CO at the validation meeting. This first draft Country Program Evaluation Report or "Evaluation Report" will be submitted to the Evaluation Reference Group for comments (in writing). The Evaluation Report template is outlined in Annex 5. The Evaluation Manager in coordination with the Regional M&E Adviser will use the Evaluation Quality Assessment Grid (Annex 6) to assess the quality of the Evaluation Reports. Comments made by the reference group and consolidated by the Evaluation Manager will then allow the evaluation team to revise the Evaluation Report.

#### *5) Dissemination, management response and Follow-Up Phase*

In this final phase, the revised or second draft evaluation report will form the basis for an in-country dissemination meeting/presentation, which will be attended by the CO as well as all the key program stakeholders (including key national counterparts). The CO will support the evaluation team with the logistics for this dissemination meeting (e.g. venue booking, catering and invitations).

The final Evaluation Report will be drafted shortly after the seminar, taking into account comments made by the participants. During this phase, the Country Office will prepare a Management Response (Annex 7) to the evaluation. The final Evaluation Report, along with the Management Response, will be published in the UNFPA evaluation database. The evaluation report will also be made available to the UNFPA Executive Board and will be widely distributed within and outside the organization.

## **7. EXPECTED OUTPUTS/DELIVERABLES**

The evaluation team will produce the following deliverables:

1. A Design Report which includes the following: a) a stakeholder map; b) the evaluation matrix (including the final list of evaluation questions and indicators); c) the overall evaluation design and methodology, with a reconstructed ToC, a detailed description of the data collection plan for the field phase; d) a description of the roles and responsibilities of the individual team members and level of effort of each team member, and e) a detailed work plan. Note: The evaluation team will collect data using the proposed methodologies: desk review, observation, interviews and focus group discussions including participation of relevant stakeholders. The evaluation team will develop a full methodology including data gathering and analysis methods as part of the Design Report.
2. A completed Evaluation Matrix which summarizes the core aspects of the evaluation exercise – it specifies *what* will be evaluated and *how*.

3. A PowerPoint presentation highlighting the main components of the Design report, and presented to the ERG with comments provided by the ERG and other key stakeholders incorporated into the final design report.
4. A PowerPoint presentation (at the end of the country visit) synthesizing the main preliminary findings, conclusions and recommendations of the evaluation, to be presented and discussed with the CO during the debriefing meeting.
5. A draft Evaluation Report followed by a second draft, taking into account potential comments from the Evaluation Reference Group.
6. A PowerPoint presentation of the results of the evaluation for the dissemination seminar to be held in Port Moresby;
7. A final Evaluation Report based on comments expressed during the dissemination seminar. The Report will include a set of clear, forward-looking and actionable recommendations logically linked to the findings and conclusions, and identify lessons learnt to improve the strategies, implementation mechanism, and management of the next Country Program.

All deliverables will be drafted in English.

## 8. PROPOSED WORK PLAN / INDICATIVE TIMEFRAME

The table below outlines the proposed work plan and indicative time frame for each of the deliverables:

Phases	Methods	Dates (workdays, max)
1. Preparatory	Letter sent to the Department of National Planning and Monitoring to inform about the CPE	Feb 2016
	Drafting terms of reference (TOR) in consultation with APRO, and Approval of TOR by EO	Mar – May 2016
	Compilation of initial list of documents, Atlas information and preliminary stakeholder map	Mar 2016
	Setting up the Evaluation Reference Group (ERG)	Apr 2016
	Selection of the evaluation consultants	Jun 2016
2. Design	Submitting a Design Report presenting the evaluation design including the approach and methodology (evaluation criteria, evaluation questions, selection of methods/tools, mapping stakeholders); and detailed evaluation plan.	Jul 2016 (5 workdays)
3. Field Phase	Conducting a three-week mission for data collection and analysis	July 2016 (20 workdays inclusive of travel)
	Formulating the preliminary findings and recommendations for debriefing meeting	Aug 2016 (2 workdays)
4. Reporting	Producing the first draft of CPE Report for sharing	Aug 2016 (10 workdays)
	Producing the second draft of CPE Report for sharing	Sep 2016



Phases	Methods	Dates (workdays, max)
		(5 workdays)
	Conducting consultation meetings with key stakeholders and Evaluation Reference Group to validate key findings, conclusions and recommendations	Sep 2016 (2 workday)
	Conducting the Evaluation Quality Assurance (EQA) by CO & APRO – with feedback given to evaluators. Producing the final CPE Report	Oct 2016 (5 workdays)
	Final EQA by Evaluation Office (in HQ)	Oct 2016
	Disseminating the final CPE Report (seminar, if needed)	Oct 2016 (1 workday)
5. Management response, dissemination and follow-up	Distributing the CPE Report to stakeholders, APRO and HQ to obtain responses to recommendations (management responses)	Oct 2016
	Uploading the CPE Report, final EQA and Management Response to UNFPA evaluation webpages, UNFPA/HQ/PD and CO's websites	Nov 2016
	Submitting the CPE Report to UNFPA Executive Board along with a new draft Country Program Document	Feb 2017

## 9. COMPOSITION AND QUALIFICATIONS OF THE EVALUATION TEAM

It is expected that the core evaluation team will consist of three members:

1. A Team Leader, with overall responsibility for carrying out the evaluation exercise.
2. Two Thematic Consultants (national), who will provide the expertise in the core subject areas of the evaluation, and be responsible for supporting the evaluation exercise.

All members of the evaluation team must have considerable knowledge and experience in conducting complex evaluations in developing countries, including strong regional experience and preferable have worked on evaluations in the Pacific or in Papua New Guinea. Team members should have technical expertise on one or more of UNFPA's mandate areas (sexual and reproductive health, population, youth and/or gender) and be committed to respecting deadlines of delivery outputs within the agreed time- frame. All team members should be knowledgeable of issues pertaining to gender equality and must be able to work in a multidisciplinary team and a multicultural environment. All the members of the evaluation team should be independent from any organizations that have been involved in designing, executing or advising any aspect of the UNFPA program.

### *The Team Leader (international consultant)*

The Team Leader is tasked with managing and ensuring the quality of the work conducted by evaluation team members and has ultimate responsibility for delivering results – s/he will be responsible for the quality and timeliness of all deliverables and for guiding and supervising the other consultants.

#### Competencies for the Team Leader

1. Experience leading and conducting complex evaluations.
2. Development sector background.
3. Excellent analytical, writing and communication skills.
4. Leadership and good management skills.
5. Ability to work with a multi-disciplinary team of experts.
6. Excellent problem identification and solving skills.
7. Excellent written and spoken English.

#### Qualifications and experience of Team Leader

1. Minimum of Master's Degree in social sciences, development studies or a related field.
2. Minimum of 10 years' experience in conducting/managing program evaluations.
3. Experience in gender mainstreaming and management of cross cutting themes.
4. Familiarity with the UNFPA work will be an added advantage.
5. Familiarity with DaO country context will be an advantage.

#### Roles and responsibilities of the Team Leader

1. Provide overall leadership to the evaluation team.
2. Provide the inputs for quality aspects of the overall process.
3. Compile the design report with the inputs from national consultants.
4. Compile draft and final reports and deliver them on time, considering the quality aspects. The Team Leader will have primary responsibility for the timely completion of a high-quality evaluation that addresses all the items required in this TOR.
5. Responsible for debriefing the findings when required.
6. Liaise with Evaluation Manager.

#### *Competencies for the Thematic Consultants*

1. Excellent analytical, writing and communication skills.
2. Ability to work with a multi-disciplinary team of experts.
3. Excellent problem identification and solving skills.
4. Excellent written and spoken English language skills.
5. Should be able to provide deliverables on time.

#### Qualifications and experience of Thematic Consultants

1. Should be an expert (with at least 7 years of experience) on reproductive and maternal health (including family planning, emergency obstetric and newborn care), or population and development, or gender.
2. At least 3 years of experience in conducting evaluations in reproductive health, population and development, or gender equality issues.

#### Roles and responsibilities of the Thematic Consultants

1. Contribute to the preparation of the design report within the UNFPA standards.
2. Evaluate each thematic section of the country program.
3. Take part in the data collection during the design and field phases.
4. Be involved in the debriefing to the CO.
5. Deliver quality inputs on time.
6. Responsible for drafting key parts of the Design Report and of the final Evaluation Report.

## **10. REMUNERATION AND DURATION OF THE CONTRACT**

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

- 50 workdays for the Team Leader;
- 40 workdays each for the two Thematic Consultants.

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

- Upon satisfactory completion of the Design Report: 20%
- Upon satisfactory completion of the draft final Evaluation Report: 50%
- Upon satisfactory completion of the final Evaluation Report: 30%

In addition to the professional fees, Team members will receive a Daily Subsistence Allowance (DSA) to be paid per night spent at the place of the mission following UN's Daily Subsistence Allowance standard rates. DSA does not apply for days spent at place of residence. Travel costs will be settled separately from the consultancy fees.

Note that no payment will be processed until the corresponding deliverables are formally approved by the Evaluation Manager.

## **11. MANAGEMENT OF THE EVALUATION**

*The UNFPA Evaluation Manager* (i.e. International Program Coordinator based in the UNFPA Country Office) will manage the evaluation exercise and ensure the quality of the evaluation process. The Evaluation Manager will directly manage the evaluation team, including the consultancy contracts, and provide in-country assistance to the team as needed.

The Evaluation Manager will:

- Lead the development of the TOR.
- Coordinate and act as secretariat for the ERG.
- Manage the evaluation budget and ensure logistical and administrative support.
- Coordinate with UNFPA relevant units, in particular with APRO and Evaluation Office.
- Facilitate access to background documents.
- Facilitate the implementation of the evaluation process, including the field phase.
- Conduct a quality assessment of the draft evaluation report, making use of the UNFPA EQA grid and discuss its results with the Regional M&E Adviser and the evaluation team.
- Approve all deliverables and payments.
- Lead the preparation of the management response.

*The Evaluation Reference Group* will be established during the preparatory phase, and will be consulted throughout the evaluation process. The members of this group will include the UNFPA M&E Adviser at APRO, UNFPA CO managers, representatives of UN sister agencies, selected key implementing partners, other partners including the representatives of the Department of National Planning and Monitoring and the National Department of Health. [Note: the TOR of the ERG will be made available to the evaluation team]

The main functions of the Evaluation Reference Group will be to:

- Discuss the draft TOR developed by the Evaluation Manager;

- Provide the evaluation team with relevant information and documentation on the program;
- Facilitate the access of the evaluation team to key informants and stakeholders during the field phase;
- Discuss and provide feedback on the reports produced by the evaluation team;
- Advise on the quality of the work done by the evaluation team;
- Assist in feedback of the findings, conclusions and recommendations from the evaluation into future program design and implementation.

*M&E Adviser at APRO* will closely work with the Evaluation Manager in providing technical inputs to the TOR, recruitment of evaluators, provide comments to the Design Report, quality assessment (EQA) for the final CPE report, CPE management response, and support the Country Office in the dissemination of the CPE. *The EQA process* involves: (a) a quality assessment of the draft final Evaluation Report by the CO Evaluation Manager; (b) a quality assessment by the M&E Adviser at APRO; (c) a final independent quality assessment by the Evaluation Office at UNFPA/HQ.

*The UNFPA Evaluation Office (EO)* in New York will be involved in approving the TOR of the evaluation, pre-qualification of the evaluation team, and quality assessment of the final evaluation report. The EO will publish the CPE report and accompanying independent EQA grid in the UNFPA Evaluation Database.

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*Surveys and Studies (hard copies will be provided by the CO)*

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7. Papua New Guinea National HIV & AIDS Strategy 2011-2015

### **13. ANNEXES**

Annex 1: Ethical Code of Conduct

Annex 2: List of Atlas Projects

Annex 3: Design Report Template

Annex 4: Evaluation Matrix Template

Annex 5: Evaluation Report Template

Annex 6: Evaluation Quality Assessment Grid

Annex 7: Management Response

## ANNEX 2A – PEOPLE INTERVIEWED

Organization	Name	Title
ARB Community Development Department	Justin Boucher	Principal Advisor
ARB Health Department	Clement Tativun	Health Secretary
ARB Women's Federation	Judith Oliver	Acting Director
Australian Dept. for Foreign Affairs & Trade	Lara Andrews	First Sec. Development Coordination
Australian Dept. for Foreign Affairs & Trade	Getrude	Program Manager
Buka Police, Family Sexual Violence Unit	Joyce Tseraha	OIC Buka FSV Unit
Department of National Planning and Monitoring	Christine Aisoli	Planning Officer
Divine Word University	Betty Koka	Academic (Ex UNFPA)
Enga Provincial Health Authority	Aron Luai	CEO
Family & Sexual Violence Action Committee	Ume Wainetti	National Coordinator
Family & Sexual Violence Action Committee	Isi Ori	Senior Program Coordinator
Family & Sexual Violence Action Committee	Rebecca Robinson	Program Advisor
IPPF/PNGFHA	Michael Salini	Interim Country Director PNGFA
Lae Police, Family Sexual Violence Unit	Ruth Murup	FSVAC Coordinator
Marie Stopes Intl	Maarten van de Reep	Country Director Port Moresby
Marie Stopes Intl ARB	Claire Kouro	Provincial Manager
Marie Stopes Intl Lae	Jeremy Mulung,	Lae Provincial Manager
Morobe Area Medical Store	Malcolm Sabak	Manager - Lae Area Medical Store
Morobe Community Development Dept.	Kiun Kimbing	Provincial Community Development Advisor
Morobe FSVAC	Zuabe Tinning	Coordinator
Morobe Provincial Health Authority	Patricia Mitiel	Family Health Services Coordinator
National Council of Women	Theresa Jaintong	President
National Council of Women	Jane Keni	Treasurer & General Secretary
National Dept. of Health	Bill Lagani	Manager Family Health Division
National Dept. of Health	Daphne Ian-Chabi	Technical Advisor RHCS program
National Dept. of Health	Martha Pogo	ARSH Officer
National Statistics Office	Henao Kari	Deputy Director
National Statistics Office	Kit Ronga	Consultant
National Statistics Office	Hajily Kele	Head Population & Social Statistics Division
National Youth Development Authority	Mr. Lasaka	Acting Director
Port Moresby General Hospital	Glen Mola	Professor Obs/Gyn
Reproductive Health Training Unit	Miriam O'Connor	Director

Organization	Name	Title
Royal PNG Constabulary	Delilah Sendaka	Police Officer FSVU
Safe Motherhood Alliance	Catherine Fokes	Program Director
UN Office ARB	Lawrence Bassie	PBF Coordinator
UN Office ARB	Jessica Siriosi	Monitoring and Evaluation Officer
UN Women	Danielle Winfrey	UN Gender Task Team Coordinator
UN Women	Beatrice Tabebu	National Program Specialist
UNAIDS	Stuart Watson	Country Representative
UNDP	John Keating	Monitoring and Evaluation Specialist
UNDP	Hermansu Roy Trivedy	UN Resident Coordinator
UNFPA	Walter Mendonca - Filho	Country Representative
UNFPA	Gilbert Hiawalyer	Deputy Country Representative
UNFPA	Cindy Milford	International Program Coordinator
UNFPA	Emma Powan	Youth & Population Program Manager
UNFPA	Debbie Kupesan	Supplies & Commodities Program Manager
UNFPA	Steven Panu	Gender and Youth Program Manager
UNFPA	Ruth Pisi	Program Assistant
UNICEF	Asefa Dano	Chief Child Protection
University of PNG	Garua Peni	Director Student Services & Peer Education
WHO	Rufina Tatu	MO Maternal & Child Health
World Vision Australia	Stella Rumbam	Operations Manager
YWCA	Dianne Kambanei	General Secretary
YWCA	Winnie Momoulek	Project Manager Tokstret

Focus Group Discussion Morobe Provincial Health Authority	Patricia Mitiel, Family Health Service Coordinator Ken Mesere, Technical Officer Public Health Mathew Moylan, Health Management Advisor DFAT Lynna A Japu, Deputy Family Health Services Coordinator Jack Aita, Deputy Principal Advisor Health Wani Bopi, Provincial Health Promotion Officer Lucy Mendal, Family Planning Coordinator Caroline Kawage, EPI Officer Paul Yaussen, Lae Family Planning Association
Focus Group Discussion Family Support Centre Buka	Sr. Esa Barnaba, Sister in Charge Jo Anne, VSO NZ Volunteer Dollorita, Trauma Counselor Serah Sabia, Trauma Counselor Sr. Virginia, Nazareth Centre for Rehabilitation

Focus Group Discussion Lae Family Planning Training Participants	Rena Dickson, Nursing Officer Urban Clinic Ame Tinki, Nursing Officer Matilda Maborai, Menyamya rural HC Christensia Semoso, Wamparr HC Huon Gulf
Focus Group Discussion Youth ARB, Training Participants	Julie Siawa, Manetai Youth Resource Centre Coordinator Martin Nakara, Arawa Youth President Gerard Takuji, Community Development Officer, Panguna Medley Koito, Arawa Women's Training Centre

## ANNEX 2B – PARTICIPANTS VALIDATION WORKSHOP

Organization	Name	Title
IPPF/PNGFHA	Mr. Michael Salini	Interim Country Director PNGFA
Marie Stopes PNG	Ms. Roselyn Aita	Trainer
Marie Stopes PNG	Ms. Marian Boeha	Project Manager
National Dept. of Health	Dr. Lahui Geida	Director Family Health Division
National Dept. of Health	Dr. Daphne Ian - Gabu	RHC Supplies technical advisor
National Statistics Office	Mr. Kit Ronga	Consultant
National Youth Development Authority	Mr. Lasaka Ladius	Acting Director
UNFPA	Ms. Cindy Milford	International Program Coordinator
UNFPA	Ms. Emma Powan	Youth & Population Program Manager
UNFPA	Ms. Debbie Kupesan	Supplies & Commodities Program Manager
UNFPA	Mr. Steven Panui	Gender and Youth Program Manager
UNFPA	Ms. Ruth Pisi	Program Assistant
University of PNG	Mr. Benaiah Nari	Team leader Peer education
University of PNG	Ms. Garua Peni	Director Student Services & Peer Education
WHO	Ms. Maera Peek	JPO
WHO	Dr. Rufina Tatu	MO Maternal & Child Health
WHO	Ms. Jessica Yaipupu	Gender specialist
WHO	Ms. Debbie Gray	Gender desk
YWCA	Ms. Winnie Momoulek	Project Manager Tokstret



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## ANNEX 4 EVALUATION MATRIX

EQ!. To what extent is the UNFPA support (i) adapted to the needs of the population; and (ii) in line with the priorities set by the international and national policy frameworks? Do planned interventions adequately reflect the goals stated in the Common Country Program Document (CCPD)?			
Assumptions to be assessed	Indicators	Sources of information	Methods for data collection
The UNFPA CCPD and relevant APWs contain a needs assessment, where possible participatory	<ol style="list-style-type: none"> <li>Evidence of needs assessment before to programming the CCPD &amp; AWP</li> <li>Extent to which UNFPA supported interventions targeted the most vulnerable, disadvantaged, marginalized and excluded population groups in a prioritized manner.</li> </ol>	<ol style="list-style-type: none"> <li>UNDAF &amp; CCPD</li> <li>AWPs</li> <li>National policy/strategy documents</li> <li>Needs assessment studies</li> </ol>	<ol style="list-style-type: none"> <li>Document review</li> <li>Interviews UNFPA CO</li> <li>Interviews implementing partners</li> <li>KII/FGD with beneficiaries &amp; key informants</li> </ol>
CCPD and APW strategies and objectives respond to national development priorities	<ol style="list-style-type: none"> <li>Extent to which objectives and strategies of each component of the program are consistent with relevant national and sectorial policies</li> <li>Extent to which the objectives and strategies of the CCPD have been discussed and agreed upon with the national partners</li> </ol>	<ol style="list-style-type: none"> <li>CCPD</li> <li>AWPs</li> <li>National policies and strategies</li> </ol>	<ol style="list-style-type: none"> <li>Document review</li> <li>KII - UNFPA CO staff</li> <li>KII - GoPNG counterparts</li> </ol>
CCPD and relevant APWs are consistent with UNDAF and UNFPA strategic plan objectives and strategies.	<ol style="list-style-type: none"> <li>Extent to which objectives and strategies of each component of the program are consistent with the UNDAF and its guiding principles</li> <li>Extent to which objectives and strategies of each component of the program are consistent with the</li> </ol>	<ol style="list-style-type: none"> <li>CPAP</li> <li>AWPs</li> <li>UNDAF</li> <li>UNFPA strategic plan</li> </ol>	<ol style="list-style-type: none"> <li>Document review</li> <li>KII – UN partners</li> <li>KII – UNFPA CO staff</li> </ol>

**EQ1. To what extent is the UNFPA support (i) adapted to the needs of the population; and (ii) in line with the priorities set by the international and national policy frameworks? Do planned interventions adequately reflect the goals stated in the Common Country Program Document (CCPD)?**

Assumptions to be assessed	Indicators	Sources of information	Methods for data collection
	UNFPA global strategy and ICPD principles		

**EQ2 : To what extent has the sexual and reproductive health interventions achieved outcomes in term of contraception, skilled delivery, and emergency obstetric care services? <sup>125</sup>**

Assumptions to be assessed	Indicators	Sources of information	Methods for data collection
Comprehensive, gender-sensitive, high-quality SRH services are in place and accessible in underserved areas with a focus on vulnerable groups in project areas	<ol style="list-style-type: none"> <li>1. Availability of SRH services increased, including FP, EOC, and Family support clinics</li> <li>2. Uptake of EOC &amp; FP services increased, especially for vulnerable women and men</li> </ol>	<ol style="list-style-type: none"> <li>1. Monitoring reports</li> <li>2. Provincial health offices/DoH</li> <li>3. Observation services/clinics</li> </ol>	<ol style="list-style-type: none"> <li>1. Document review</li> <li>2. UNFPA CO team presentation</li> <li>3. KII MOPH/PHO, WHO, MSI, IPPF</li> <li>4. FGD health workers, service users</li> </ol>
Provincial Health Departments (in project provinces) are able to plan, deliver and monitor and deliver SRH services	<ol style="list-style-type: none"> <li>1. Evidence of provincial SRH strategic and operational plans</li> <li>2. Evidence of increased health worker capacity in FP &amp; EOC</li> <li>3. RHC security system in place and operational</li> <li>4. Maternal mortality surveillance operational</li> </ol>	<ol style="list-style-type: none"> <li>1. Monitoring reports</li> <li>2. Provincial health strategies</li> <li>3. Training reports</li> <li>4. DoH/Provincial health offices</li> </ol>	<ol style="list-style-type: none"> <li>1. Document review</li> <li>2. UNFPA CO team presentation</li> <li>3. KII MOPH/PHO, WHO</li> <li>4. FGD health workers, service users</li> </ol>
Support for	5. MISP strategy and	1. Monitoring reports	1. Document review

<sup>125</sup> Note: CCPD outcome Indicators & targets: \*(source national HMIS/DHS): 1. CPR among married women (15-49) (Baseline: 32%; Target: 40%); 2. Births attended by skilled health workers (Baseline: 40%; Target: 50%); 3. Referral rate for EOC (Baseline: 5%; Target: 10%); 4. Age Specific FR for 15-19 yrs women (Baseline: 65/1000; Target: 60/1000); 5. % men/women (15-59, with >1 sexual partner in the past 12 months) reporting condom during last intercourse (Baseline 38.9%; Target 50%).

**EQ2 : To what extent has the sexual and reproductive health interventions achieved outcomes in term of contraception, skilled delivery, and emergency obstetric care services? <sup>125</sup>**

Assumptions to be assessed	Indicators	Sources of information	Methods for data collection
innovations resulted in improved national capacity for SRH services	SOPs available 6. EMONC baseline survey report	2. National health strategies 3. DoH management	2. UNFPA CO team presentation 3. KII MOPH, WHO, UNICEF 5. FGD health workers, users

**EQ 3. To what extent has UNFPA support helped to increase the access of young people (including adolescents) to quality sexual and reproductive health (SRH) services and sexuality education?**

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for data collection
Provincial health and education departments are able and willing to plan, deliver and monitor adolescent SRH & HIV services	1. Provincial ASRH strategies developed & operational 2. Provincial school health programs developed & operational 3. Evidence of increased capacity of health workers/schools to deliver youth friendly health services	1. Provincial adolescent health strategies and plans 2. ASRH service guidelines/SOPs/training modules 3. NHATU training reports/curricula on peer education 4. Observation services	1. Document review 2. UNFPA CO team presentation 3. KII PHO, PEO, YWCA, UNPG, WHO, NHATU UNAIDS, health workers 4. FGD with youth, peer educators
Young people's access to sexual and reproductive health services and information, including sexuality education is increased through supported projects in project provinces	1. Evidence of increased coverage of supported ASRH projects (YWCA, UPNG, DoE) 2. Evidence of use of RSH/HIV prevention services by young people, in-school and out-of-school (UPNG/UoT/DoE/YWCA)	1. Progress reports implementers 2. Training modules 3. Observation services	1. Document review 2. UNFPA CO team presentation 3. KII DoH, DoE, YWCA, UNPG, WHO, UNAIDS, health workers 4. FGD with youth, peer educators

EQ 3. To what extent has UNFPA support helped to increase the access of young people (including adolescents) to quality sexual and reproductive health (SRH) services and sexuality education?				
Assumptions to be assessed	Indicators	Sources of information		Methods and tools for data collection
Youth participation and engagement in issues that affect them has increased	1. Evidence that youth parliament in Bougainville/provinces increased quality, access and use of youth SRH services	1. Progress reports implementers	2. Policy documents AROB	1. Document review 2. UNFPA CO team presentation 3. KII ABG, DCD, NYC, 4. FGD with youth AROB



<b>EQ4. To what extent have the interventions in gender contributed to (i) raising awareness on gender-based violence and (ii) positioning this theme on the national agenda<sup>126</sup>?</b>				
<b>Assumptions to be assessed</b>	<b>Indicators</b>	<b>Sources of information</b>	<b>Methods and tools for data collection</b>	
The capacity of the National Council of Women to advocate around GBV has improved	<ol style="list-style-type: none"> <li>1. NCW strategic and action plan developed, plus 4 provinces</li> <li>2. Type and number of advocacy action and their impact</li> </ol>	<ol style="list-style-type: none"> <li>1. Strategic plan and action plan</li> <li>2. Progress reports implementers</li> <li>3. NCW leadership and members</li> <li>4. Media and researchers</li> </ol>	<ol style="list-style-type: none"> <li>1. Document review</li> <li>2. UNFPA CO team presentation</li> <li>3. KII NCW, PCW, UNW</li> <li>4. FGD NCW/PCW members</li> </ol>	
Health sector response to gender based violence has improved	<ol style="list-style-type: none"> <li>1. Guidance and curriculums on GBV have been updated and used</li> <li>2. Evidence of capacity and sensitivity among managers and health workers</li> <li>3. Increased coverage &amp; uptake of post GBV services</li> </ol>	<ol style="list-style-type: none"> <li>1. Progress reports implementers</li> <li>2. Curricula, guidance, training reports</li> <li>3. Monitoring reports DoH/PHO</li> <li>4. Observation services</li> </ol>	<ol style="list-style-type: none"> <li>1. Document review</li> <li>2. UNFPA CO team presentation</li> <li>3. KII DOH, PHO, UPNG, DWU, FSVAC, UNW</li> <li>4. FGD health workers</li> </ol>	
Reporting, follow up and prosecution of GBV cases has increased in law enforcement & judiciary system	<ol style="list-style-type: none"> <li>1. Reporting system in place</li> <li>2. Number of police offers, lawyers etc. trained</li> <li>3. Increase in reporting and prosecution of GBV cases</li> </ol>	<ol style="list-style-type: none"> <li>1. Progress reports implementers</li> <li>2. Police records</li> <li>3. Training manuals and reports</li> <li>4. Observation police unit</li> </ol>	<ol style="list-style-type: none"> <li>1. Document review</li> <li>2. UNFPA CO team presentation</li> <li>3. KII RPNGC, lawyers, FSVAC, UNW</li> </ol>	

<sup>126</sup> Note Indicators & targets from the CCPD:

1. Reduction in the number of women (15-49) who experienced any form of violence in the last 12 months (Baseline tbd; Target: 5%)
2. % GBV cases reported to the police and that have been prosecuted (Baseline: 0%; Target: 5%)
3. % trained advocates who have advocated the prosecution of GBV cases (Baseline: 0; Target: 50%)
4. % married women (15-49) made joined decisions with their partners in deciding the number and spacing of their children (Baseline: tbd; Target: 20% increase)

**EQ5: To what extent have population data (demographic statistics, census data, etc.) been effectively produced and taken into account in poverty reduction strategies, policies, and plans and programs?**

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Assumptions to be assessed	Indicators	Sources of information	Methods and tools for data collection
UNFPA contributed to the national capacity to integrate population dynamics, reproductive health and gender-equality into development planning at national, sectorial and local levels	<ol style="list-style-type: none"> <li>1. National Population Policy agreed and operationalized</li> <li>2. 2011 census data analyzed and used for planning</li> <li>3. NRI monographs published and used for planning</li> </ol>	<ol style="list-style-type: none"> <li>1. National Population Policy and reports, other policies</li> <li>2. NDPM and NSO</li> <li>3. NRI</li> <li>4. Research reports</li> </ol>	<ol style="list-style-type: none"> <li>1. Document review</li> <li>2. UNFPA CO team presentation</li> <li>3. KII NDPM, NSOI, NRI, UNDP</li> </ol>
Perennial mechanisms for the integration of population variables in national and sectorial development planning are in place	<ol style="list-style-type: none"> <li>1. Budget allocation NDPM to integrate population dynamics in development planning</li> <li>2. Evidence of capacity NDPM/NSO to undertake, analyze and use census, DHS for planning</li> </ol>	<ol style="list-style-type: none"> <li>1. National Planning strategy and operational plan/budget</li> <li>2. NDPM &amp; NSO</li> </ol>	<ol style="list-style-type: none"> <li>1. Document review</li> <li>2. UNFPA CO team presentation</li> <li>3. KII NDPM, NSO, NRI, DoH, UNDP</li> </ol>

**EQ6. To what extent has UNFPA made good use of its human, financial and technical resources, and has used an appropriate combination of tools and approaches to pursue the achievement of the outcomes defined in the UNFPA country program?**

<sup>127</sup> CCPD Indicators & targets:

1. % annual, operational plans of health, education and community development departments that use key demographic data (size, population growth rate, age, gender composition and spatial distribution) (Baseline: 0%; Target: 100%)
2. # census/survey data sets disaggregated by age, sex and location that are utilized for decision-making at national and provincial levels (Baseline: 1<sup>127</sup>; Target: 3)
3. Increase in national budget allocated to sectors (health, education, community development and HIV/AIDS) directly linked to MDGs 3, 5 and 6 (Baseline: 0; Target: 20%)

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for data collection
Beneficiaries of UNFPA support received the financial and technical resources as planned and in a timely manner	<ol style="list-style-type: none"> <li>1. Funding disbursement to partners as forecast in AWP</li> <li>2. Level of resource mobilization as expected and budgeted in AWP</li> </ol>	<ol style="list-style-type: none"> <li>1. Annual reports from partners</li> <li>2. Financial reports UNFPA</li> <li>3. UNFPA program, finance &amp; admin departments</li> <li>4. Counterparts &amp; Implementers</li> </ol>	<ol style="list-style-type: none"> <li>1. Document review</li> <li>2. UNFPA CO team presentation</li> <li>3. KII partners, UNFPA admin and financial staff, grantees</li> <li>4. FGD UNFPA CO staff</li> </ol>
The mix of implementation modalities (TA, funding, direct implementation) was appropriate and cost-effective to achieve outcomes	<ol style="list-style-type: none"> <li>1. Evidence of partners' satisfaction with UNFPA support</li> <li>2. Evidence of UNFPA cost-saving implementation modalities</li> </ol>	<ol style="list-style-type: none"> <li>1. Annual reports from partners</li> <li>2. Financial reports UNFPA</li> <li>3. UNFPA program, finance &amp; admin departments</li> <li>4. Counterparts &amp; Implementers</li> </ol>	<ol style="list-style-type: none"> <li>1. Document review</li> <li>2. UNFPA CO team presentation</li> <li>3. KII partners, UNFPA admin and financial staff, grantees</li> <li>4. FGD UNFPA CO staff</li> </ol>

**EQ7. To what extent did the intervention mechanisms (financing instruments, administrative regulatory framework, staff, timing and procedures) foster or hinder the achievement of the program outputs?**

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for data collection
UNFPA internal administrative and financial procedures allow for a smooth execution of the program	<ol style="list-style-type: none"> <li>1. Appropriateness of the UNFPA administrative and financial procedures for implementation</li> <li>2. Appropriateness of the IP selection criteria</li> <li>3. UNFPA ability to mobilize sufficient resources</li> <li>4. Constraints to implementation</li> </ol>	<ol style="list-style-type: none"> <li>1. UNFPA program, finance &amp; admin departments</li> <li>2. Counterparts &amp; Implementers</li> </ol>	<ol style="list-style-type: none"> <li>1. Annual reports from partners</li> <li>2. Financial reports UNFPA</li> <li>3. KII partners, UNFPA admin and financial staff, grantees</li> <li>FGD task team</li> </ol>

**EQ8. To what extent has UNFPA been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to ensure ownership and the durability of effects?**

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for data collection
Institutions supported by UNFPA programs are integrated in the GoPNG structure	<ol style="list-style-type: none"> <li>Youth parliament functional in 4 provinces/AROB</li> <li>National Population Council, National (&amp; provincial) Womens' Councils functional</li> <li>Evidence of sustainability Peace Building Fund</li> </ol>	<ol style="list-style-type: none"> <li>Counterparts and implementers</li> <li>UNFPA and UNCT partners</li> <li>Field visit to relevant institutions</li> </ol>	<ol style="list-style-type: none"> <li>Document review</li> <li>UNFPA CO team presentation</li> <li>KII DoH, DoE, RPNGC, DCD, implementers</li> </ol>
National strategies and policies developed with UNFPA support are implemented	<ol style="list-style-type: none"> <li>Functional national strategies for RH commodity security, MISP, adolescent health, national population policy</li> <li>Functional provincial strategies for SRH, Adolescent Health, HIV/SRH peer education in and out of school,</li> <li>NSO plan for analysis &amp; dissemination of the next DHS/census</li> <li>GBV training and reporting systems are functional in health, school and law enforcement sectors.</li> </ol>	<ol style="list-style-type: none"> <li>Relevant strategies and policies</li> <li>Counterparts and implementers</li> <li>UNFPA and UNCT partners</li> <li>Field visit &amp; observation</li> </ol>	<ol style="list-style-type: none"> <li>Document review</li> <li>UNFPA CO team presentation</li> <li>KII DoH, DoE, RPNGC, DCD, implementers</li> </ol>
Innovations and service models supported by UNFPA are adopted by counterpart departments	<ol style="list-style-type: none"> <li>MSI FP service adopted by PHO</li> <li>Tokstret program adopted by DoH</li> </ol>	<ol style="list-style-type: none"> <li>Counterparts and implementers</li> <li>UNFPA and UNCT partners</li> </ol>	<ol style="list-style-type: none"> <li>Document review</li> <li>UNFPA CO team presentation</li> <li>KII PHO, PEO, implementers</li> </ol>

**EQ9. To what extent has the UNFPA country office contributed to the functioning and consolidation of UNCT coordination mechanism?**

Assumptions to be	Indicators	Sources of	Methods and tools
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assessed		information	for data collection
The UNFPA country office actively contributes to UNCT task teams and joint work plans.	<ol style="list-style-type: none"> <li>1. Evidence of active participation in UN working groups</li> <li>2. Evidence of a leading role by UNFPA in task teams and/or joint initiatives that correspond to its mandate areas</li> <li>3. Evidence of exchanges of information between UN agencies</li> <li>4. Evidence of joint programming &amp; planning</li> <li>5. Evidence of joint implementation of programs</li> </ol>	<ol style="list-style-type: none"> <li>1. UNDAF document</li> <li>2. CCPD document</li> <li>3. AWP for task teams, minutes of meetings</li> <li>4. Progress reports AWP</li> <li>5. Other UN agencies, UNCT, UNRC</li> </ol>	<ol style="list-style-type: none"> <li>6. Document review</li> <li>7. KII with UNFPA CO, UNRC, other UN agencies</li> </ol>

**EQ10. What are the main UNFPA added value and comparative strengths in the country – particularly in comparison to other UN Agencies as perceived by national stakeholders? Are these strengths a result of UNFPA corporate features or are they specific to the CO features?**

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for data collection
UNFPA strategies and interventions in SRH and Adolescent RSH add value to the work of other development partners, especially the UN system	<ol style="list-style-type: none"> <li>Evidence of the quality of UNFPA TA</li> <li>UNFPA funding relative to other donors</li> <li>Evidence of appreciation key stakeholders</li> </ol>	<ol style="list-style-type: none"> <li>Consultancy/training reports</li> <li>UFPA progress reports</li> <li>National Planning Documents</li> <li>GoPNG counterparts</li> <li>Development partners &amp; NGOs</li> </ol>	<ol style="list-style-type: none"> <li>Document review</li> <li>KII UNRC, DOH, UN agencies, donors (DFAT, WB, USAID)</li> <li>FGD UNFPA CO team</li> </ol>
UNFPA strategies and interventions in population and development add value to the work of other development partners, especially the UN system	<ol style="list-style-type: none"> <li>Evidence of the quality of UNFPA TA</li> <li>Funding from UNFPA relative to other donors</li> <li>Evidence of appreciation key stakeholders</li> </ol>	<ol style="list-style-type: none"> <li>Consultancy/training reports</li> <li>UFPA progress reports</li> <li>National Planning Documents</li> <li>GoPNG counterparts</li> <li>Development partners &amp; NGOs</li> </ol>	<ol style="list-style-type: none"> <li>Document review</li> <li>KII UNRC, NDPM, UN agencies, donors (DFAT, WB, USAID)</li> <li>FGD UNFPA CO team</li> </ol>
UNFPA strategies and interventions in gender add value to the work of other development partners, especially the UN system	<ol style="list-style-type: none"> <li>Evidence of the quality of UNFPA TA</li> <li>Funding from UNFPA relative to other donors</li> <li>Evidence of appreciation key stakeholders</li> </ol>	<ol style="list-style-type: none"> <li>Consultancy/training reports</li> <li>UFPA progress reports</li> <li>National Planning Documents</li> <li>GoPNG counterparts</li> <li>Development partners &amp; NGOs</li> </ol>	<ol style="list-style-type: none"> <li>Document review</li> <li>KII UNRC, DCD, UN agencies, donors (DFAT, WB, USAID)</li> <li>FGD UNFPA CO team</li> </ol>

## ANNEX 5 - UNFPA PNG COUNTRY PROGRAM - PROJECTS AND OUTPUTS PER UNFPA PROGRAM AREA 2012-2016

### Sexual and reproductive health & rights

Planned activities & support method <sup>128</sup>	Evidence of progress as of 2016 <sup>129</sup>	Joint UN/UNFPA	UN task team
<b>1. National SRHR Policy development and advocacy</b>			
NDOH advocacy on FP and RH policy development	<ul style="list-style-type: none"> <li>Nat FP policy '14 (agreed '12)</li> <li>National SRH policy agreed '12</li> <li>Nat Gender &amp; Health policy '14 (agreed '12)</li> <li>National Youth &amp; Adolescent Health policy '14 (agreed '12)</li> </ul>	UNFPA/WHO	Health
	<ul style="list-style-type: none"> <li>Co-funding National FP awareness meeting for decision makers on national FP policy, '13<sup>130</sup> &amp; '14<sup>131</sup></li> <li>Funding logistics World Population Day'16</li> <li>Funding for SMALL national safe motherhood meeting &amp; social media work '16<sup>132</sup></li> </ul>	UNFPA	Health
MDG Radio Advocacy campaign	<ul style="list-style-type: none"> <li>"Echoes of Change/Nau em taim", episodes on FP, RSH, HIV '12 -'13</li> <li>Evaluation radio campaign '13</li> </ul>	UNFPA/ UNDP/ UNICEF	MDG & Pop
TA for HIV peer education sex workers Involvement in HIV taskforces and advocacy	<ul style="list-style-type: none"> <li>UNFPA Regional Office training key population services '14</li> <li>TA national peer education manual Key Populations '15/'16</li> <li>Involvement regional/country office in advocacy legal reform</li> </ul>	UNFPA/ UNAIDS / UNICEF	JUNTA
<b>2. Provincial health system strengthening</b>			
FP awareness forums for provincial decision	<ul style="list-style-type: none"> <li>AROB: forum for 200 decision makers '15<sup>133</sup></li> </ul>	UNFPA/ WHO	Health

<sup>128</sup> Source: UNDAF task team annual workplans & UNFPA project agreements

<sup>129</sup> Source: 1) UNFPA program team presentation; 2) UNDAF & UNFPA progress reports; 3) Project/study reports; 4) Key Informant Interviews

<sup>130</sup> RHCS annual report 2013 – resulting in call from PM to local govts to make more resources available for FP

<sup>131</sup> pers. comm. MSI, WHO & SMALL

<sup>132</sup> pers. comm. SMALL

<sup>133</sup> MSI AROB pers. comm. – not in report

Planned activities & support method <sup>128</sup>	Evidence of progress as of 2016 <sup>129</sup>	Joint UN/UNFPA	UN task team
makers on national FP policy	<ul style="list-style-type: none"> <li>• Morobe: FSVAC 30 health managers '15</li> <li>• Kimbe, Mt. Hagen &amp; Morobe decision makers '16<sup>134</sup></li> </ul>		
Provincial roll out MSI/NDOH FP training (\$ for per diem)	<ul style="list-style-type: none"> <li>• Total 200 HW trained/2 year; UNFPA co-funding for trainings in Morobe/Central only<sup>135</sup></li> <li>• Morobe: 3 ('14) &amp; 3 ('15) total 37 trainees</li> <li>• Central: 1 ('16)<sup>136</sup>,</li> <li>• 2 trainings in Goroka 2015, 2016</li> <li>• 1 training in Gulf (monitoring) 2015</li> <li>• 1 monitoring in Central, Morobe, Goroka in 2016</li> </ul>	UNFPA	Health
Provincial roll out RHTU/DOH EOC/EMOC (\$ for per diem)	<ul style="list-style-type: none"> <li>• 18 training courses in 3/4 provinces (10-15 HW/ training)<sup>137</sup></li> <li>• ±225 total trainees supported by UNFPA<sup>138</sup></li> <li>• Morobe: 7 EOC trainings (#105) and 3 EMOC trainings (#30)</li> <li>• AROB: #20 HW '15</li> <li>• Enga: started late (no info on #)<sup>139</sup></li> <li>• Central: no training (nobody showed)<sup>140</sup></li> </ul>	UNFPA/WHO	Health
NZA left over grant used for extra MCH training HW ('12)	<ul style="list-style-type: none"> <li>• midwife clinical training</li> <li>• 1 NDOH TOT on FP for provincial managers</li> <li>• 1 In service training for Ob/Gyn specialists</li> </ul>	UNFPA	none
NDOH maternal death audit	<ul style="list-style-type: none"> <li>• developed by WHO, not implemented yet</li> <li>• provincial visits, 4 committees set up, '12</li> <li>• Provincial advocacy visits with WHO to AROB, also Kimbe, Mt Hagen</li> </ul>	WHO/ UNFPA	Health

<sup>134</sup> pers. comm. MSI<sup>135</sup> pers. comm. MSI<sup>136</sup> during CPE<sup>137</sup> presentation UNFPA<sup>138</sup> pers. comm. RHTU<sup>139</sup> pers. comm. RHTU<sup>140</sup> pers. comm. RHTU



Planned activities & support method <sup>128</sup>	Evidence of progress as of 2016 <sup>129</sup>	Joint UN/UNFPA	UN task team
Training health department on RH in emergencies by IPPF/FPA	<ul style="list-style-type: none"> <li>• (National TOT '10 &amp; 4 regional trainings '11-'12)</li> <li>• Co-funding &amp; facilitation 2 IPPF trainings, East New Britain '15 &amp; NCD '16 (2x±30 trainees)<sup>141</sup></li> </ul>	UNFPA (MISP)	Health
Provision for NDOH, MSI & IPPF clinics (commodities) Basic logistics training health workers (TA, \$, mgmt.) M&E (consultancy)	<ul style="list-style-type: none"> <li>• FP supplies (40,000 male/120,000 female condoms &amp; 400,000 implants) to NDOH (as needed) '13-'16</li> <li>• FP supplies to MSI '14-'16 (\$200,000/year, whole range)</li> <li>• FP supplies to IPPF '16 (limited)</li> <li>• Staff position in NDOH/FHD for supplies</li> <li>• 6 level-1 logistics trainings: <ul style="list-style-type: none"> <li>• 3x training Morobe, AROB &amp; Mt Hagen (#87) in '13<sup>142</sup></li> <li>• 2x training Morobe '12, FU supervision &amp; TA '13</li> <li>• 2x training Madang, Manus in '14</li> <li>• 2x training Oro/AROB in '15</li> <li>• None in Central/Enga!</li> </ul> </li> <li>• co-funding of training on m-supply software<sup>143</sup></li> <li>• RSH situation analysis '14</li> <li>• Evaluation: Health facility survey for evaluation '15</li> </ul>	UNFPA (Supplies)	Health
	<ul style="list-style-type: none"> <li>• Extra Implant procurement &amp; supply (new) '12</li> </ul>	UNFPA (extra)	NA
<b>3. Support service delivery</b>			
YWCA radio program on RSH (grant)	<ul style="list-style-type: none"> <li>• Radio talk show biweekly on government radio '12-'15 (Tokstret)</li> <li>• no evaluation, no TA</li> </ul>	UNFPA	Health
MDSI FP services by MSI, introducing implant (grant)	<ul style="list-style-type: none"> <li>• Financial support for FP services (2013) (150,000 US\$)</li> <li>• Target 2013: 2759 clients and 8784 CYP, including implant<sup>144</sup>.</li> </ul>	UNFPA	Health

<sup>141</sup> source: training report & pers. comm. IPPF

<sup>142</sup> RHCS report 2013

<sup>143</sup> pers. comm. WVI

<sup>144</sup> agreement UNFPA-MSPNG 2013

Planned activities & support method <sup>128</sup>	Evidence of progress as of 2016 <sup>129</sup>	Joint UN/UNFPA	UN task team
	<ul style="list-style-type: none"> <li>(Achievement MSI '14: #7,205 clients, 15,813 CYP (total)<sup>145</sup>)</li> <li>No evaluation</li> </ul>		
Start up cost IPPF office in NCD	<ul style="list-style-type: none"> <li>US\$ 48,000 in '15/'16<sup>146</sup></li> </ul>	UNFPA	

## Adolescents and youth

Planned activities & support method <sup>147</sup>	Evidence of progress as of 2016 <sup>148</sup>	Joint UN/UNFPA	UN task team
<b>1. Policy development &amp; advocacy</b>			
NYDA develop Youth Policy	<ul style="list-style-type: none"> <li>Review National Youth Policy 2007-2017 postponed<sup>149</sup></li> </ul>	UNFPA/ UNDP	MDG & Pop
NDOH ARSH policy and limited training (TA & \$)	<ul style="list-style-type: none"> <li>Participation in national ARSH TWG (WHO lead)</li> <li>Youth &amp; Adolescent Health Policy agreed '12 (not yet implemented, no training)</li> <li>Advocacy meetings on youth access to RSH '13/'14</li> <li>Training 20 DOH managers on ARSH (40 planned) '15</li> </ul>	UNFPA/ WHO/ UNICEF	Health
DoE support for rolling out HIV education and Comprehensive Sex Education curriculum development (TA)	<ul style="list-style-type: none"> <li>DoE development of curriculum and training of Teachers on SRH '12</li> <li>YWCA development of curriculum and teaching of SRH to in/out of school students '12</li> <li>Morobe 1 training for Health/ Education sector (20 trainees) '14</li> <li>Stopped in '16 due to capacity/interest issues</li> </ul>	UNFPA	Health
NACS update out-of-school HIV peer education guidelines (TA & \$)	<ul style="list-style-type: none"> <li>No progress</li> </ul>	UNFPA/ UNAIDS/ UNICEF	JUNTA

<sup>145</sup> RHCS annual report 2014

<sup>146</sup> pers. comm. IPPF

<sup>147</sup> Source: UNDAF task team annual workplans & UNFPA project agreements

<sup>148</sup> Source: 1) UNFPA program team presentation; 2) UNDAF & UNFPA progress reports; 3) Project/study reports; 4) Key Informant Interviews

<sup>149</sup> pers. comm. NYDA act. Director

Planned activities & support method <sup>147</sup>	Evidence of progress as of 2016 <sup>148</sup>	Joint UN/UNFPA	UN task team
<b>2. Capacity building for ARSH service improvement</b>			
	<ul style="list-style-type: none"> <li>• Provincial youth policies:               <ul style="list-style-type: none"> <li>• AROB youth policy '12</li> <li>• Morobe Provincial Youth Development Plan drafted (NYDA/UNFPA support) '15</li> <li>• Enga provincial youth plan '12<sup>150</sup></li> </ul> </li> <li>• Provincial ARSH policies               <ul style="list-style-type: none"> <li>• Morobe: advocacy meeting with PHO (50 youth)<sup>151</sup></li> </ul> </li> </ul>	UNFPA	Health
NYDA establish/strengthen youth council in 4 provinces (\$)	<ul style="list-style-type: none"> <li>• Provincial youth federation in AROB' 12 (now defunct<sup>152</sup>)</li> <li>• Enga youth council '12; leadership training &amp; advocacy '15<sup>153</sup></li> </ul>	UNFPA	MDG & Pop
NACS support for 4 Provincial AIDS Committees to organize youth IEC, leadership (TA & \$) <sup>154</sup>	<ul style="list-style-type: none"> <li>• No progress</li> </ul>	UNFPA/ UNAIDS / UNICEF	JUNTA
<b>3. ARSH service delivery</b>			
YWCA out of school peer education	<ul style="list-style-type: none"> <li>• Annually 2 week-long trainings @ 20 young people = 200 total<sup>155</sup></li> <li>• All 4 priority provinces (no other provinces)</li> <li>• No follow up on peer education activities &amp; reach<sup>156</sup></li> </ul>	UNFPA	Health
UPNG peer education on HIV & RH (\$ & trainers)	<ul style="list-style-type: none"> <li>• PE manual developed with UNPFA TA (1997)</li> <li>• Ongoing in NCD from '12 – no evaluation</li> <li>• 1 PE training/year; 25-30 PE trained/year</li> <li>• 600 counseled/yr.; 2,000 reached/yr.<sup>157</sup> (7,000 until '14)</li> </ul>	UNFPA	Health

<sup>150</sup> pers. comm. NYDA act. Director<sup>151</sup> pers. comm. PHO Morobe<sup>152</sup> pers. comm. NYDA act. Director<sup>153</sup> pers. comm. NYDA act. Director<sup>154</sup> AWP 2013<sup>155</sup> pers. comm. YWCA<sup>156</sup> pers. comm. YWCA<sup>157</sup> pers. comm.: Director UPNG program

Planned activities & support method <sup>147</sup>	Evidence of progress as of 2016 <sup>148</sup>	Joint UN/UNFPA	UN task team
<ul style="list-style-type: none"> <li>- NACS update out-of-school guidelines (TA &amp; \$)</li> <li>- Support for 4 provincial AIDS Committees<sup>158</sup></li> <li>- 4 PACs organize youth IEC, leadership (TA &amp; \$)<sup>159</sup></li> <li>- TA for peer education key populations</li> <li>- Involvement in HIV taskforces and advocacy</li> <li>- Grant YWCA for out of school peer education</li> </ul>	<ul style="list-style-type: none"> <li>• (Out-of-school peer education : see Adolescent Program)</li> <li>• UNFPA Regional Office training key population services '14</li> <li>• TA national peer education manual Key Populations '15/'16</li> <li>• Involvement regional/country office in advocacy legal reform</li> </ul>	UNFPA/ UNAIDS / UNICEF	JUNTA
<b>4. Youth services for peace in Bougainville</b>			
NYDA organize AROB youth parliament (\$)	<ul style="list-style-type: none"> <li>• Co-funding and facilitation 1 mock parliament AROB<sup>160</sup> '13</li> </ul>	UNFPA/ UNDP	MDG & Pop
Self-management training 180 youth Establishment 3 youth centers (\$)	<ul style="list-style-type: none"> <li>• Co-funding and facilitation NYDA training for post conflict young people. Pilot '13 (#30), 2 more in '15 (#60)<sup>161</sup></li> <li>• 1 temporary center'15, proposal for final center</li> </ul>	UNFPA/ UNDP	Bougainville
WVI/DCD/NYDA organize mock youth parliament	<ul style="list-style-type: none"> <li>• Co-planning, co-funding and co-facilitation in '15</li> <li>• One participant has become MP</li> </ul>	UNFPA/ UNDP	Bougainville

## Population and development

Planned activities & support method <sup>162</sup>	Evidence of progress as of 2016 <sup>163</sup>	Joint UN/UNFPA	UN task team
<b>1. Policy development and advocacy</b>			
DNPM to revise/ratify national population policy (TA, mgmt.), and national population days (\$)	<ul style="list-style-type: none"> <li>• Funding for Special Interventions branch in the DNMP '12</li> <li>• Training for information &amp; analysis to inform national strategies '13, '14</li> </ul>	UNFPA	MDG & Pop Health

<sup>158</sup> AWP 2013

<sup>159</sup> AWP 2013

<sup>160</sup> pers. comm. NYDA act. Director

<sup>161</sup> pers. comm. NYDA act. Director

<sup>162</sup> Source: UNDAF task team annual workplans & UNFPA project agreements

<sup>163</sup> Source: 1) UNFPA program team presentation; 2) UNDAF & UNFPA progress reports; 3) Project/study reports; 4) Key Informant Interviews

Planned activities & support method <sup>162</sup>	Evidence of progress as of 2016 <sup>163</sup>	Joint UN/UNFPA	UN task team
	<ul style="list-style-type: none"> <li>Set up Parliamentary Group on Population &amp; Development '13<sup>164</sup></li> <li>National Population Policy Vol. 1 '12, Population Policy on Implementation being printed, Vol. 2 '16</li> <li>UNFPA hosted Nat Pop days '12, '13 &amp; '16: ('16 focus on teenage girls), held each year<sup>165</sup></li> <li>National Strategy for Responsible Sustainable Development (includes population data) '14,</li> </ul>		
NSO document and disseminate 2011 Census (\$ & TA consultancy)	<ul style="list-style-type: none"> <li>2011 Census printed '14</li> </ul>	UNFPA	MDG & Pop
NRI publication census based population monographs (\$ & TA consultancy)	<ul style="list-style-type: none"> <li>Fertility report draft '16</li> <li>Mortality report draft '16</li> <li>NRI member PhD support</li> </ul>	UNFPA	MDG & Pop
NSO undertake/disseminate 2016 DHS (TA/mgmt.)	<ul style="list-style-type: none"> <li>Preparation &amp; design ongoing since 2016 (DFAT grant \$7.4m)</li> </ul>	UNFPA	MDG & Pop
NSO set up vital registration at village level	<ul style="list-style-type: none"> <li>Cancelled because GoPNG moved to National ID system</li> </ul>	UNFPA	MDG & Pop
<b>2. Capacity building for provincial policy implementation and roll out</b>			
NSO document and disseminate 2011 Census provincial reports (TA consultancy)	<ul style="list-style-type: none"> <li>Prov. reports drafted '16</li> <li>Database "Community Profile System" '15</li> </ul>	UNFPA	MDG & Pop

## Gender and women's empowerment

<sup>164</sup> Source, Emma, Validation Workshop.

<sup>165</sup> Source, Cindy, Validation W/shop

Planned activities & support method <sup>166</sup>	Evidence of progress as of 2016 <sup>167</sup>	Joint UN/UNFPA	UN task team
<b>1. Institution building</b>			
Organizational support for NCW (machineries) (\$ and TA)	<ul style="list-style-type: none"> <li>• NCW Capacity assessment '12</li> <li>• Consultancy for NCW restructuring '16</li> <li>• Despite support little capacity</li> </ul>	UNFPA/ UNW	Gender
Strengthen provincial women councils (machineries)	<ul style="list-style-type: none"> <li>• Women's councils/federations exist, but no capacity building by NCW</li> </ul>		
<b>2. National Policy development and advocacy</b>			
TA for policy development Nat Dept. for Community Development	<ul style="list-style-type: none"> <li>• Participation development Family Protection Act '12</li> <li>• Participation in preparing National Strategy to prevent and respond to GBV 2015-2050</li> </ul>	UNFPA/ UNW/ UNDP	Gender
NCW to write CEDAW shadow report (TA)	<ul style="list-style-type: none"> <li>• No progress (no GoPNG CEDAW report yet)</li> </ul>	UNFPA/ UNW	Gender
<b>3. Health sector response to GBV</b>			
National Health sector response to GBV: - Revision GBV Manual for health workers - FSVAC develop reporting forms for FSC, train data analysts & 20 health workers; M&E visits for FSC & best practice exchange	<ul style="list-style-type: none"> <li>• Participation in development Health sector gender policy '14</li> <li>• Funding for gender focal point in NDOH FHD<sup>168</sup></li> <li>• DOH include GBV training in medical curriculum '16</li> <li>• FSVAC support to NDOH for FSC protocols &amp; training (national)<sup>169</sup></li> <li>• UNFPA/FSVAC Involvement in post GBV service SOP development (ongoing)<sup>170</sup></li> </ul>	UNFPA/ UNICEF	Gender
Provincial health sector response to GBV	<ul style="list-style-type: none"> <li>• 65 health workers trained on GBV in '12<sup>171</sup></li> <li>• Funding 15 FSVAC gender trainings * 30 health staff (AROB, Enga, Central) and non-priority provinces – focus on FSC<sup>172</sup></li> </ul>	UNFPA/ WHO	Gender

<sup>166</sup> Source: UNDAF task team annual workplans & UNFPA project agreements

<sup>167</sup> Source: 1) UNFPA program team presentation; 2) UNDAF & UNFPA progress reports; 3) Project/study reports; 4) Key Informant Interviews

<sup>168</sup> pers. comm. FSVAC

<sup>169</sup> pers. comm. FSVAC

<sup>170</sup> pers. comm. FSVAC

<sup>171</sup> UNDAF annual report 2012

<sup>172</sup> pers. comm. FSVAC

Planned activities & support method <sup>166</sup>	Evidence of progress as of 2016 <sup>167</sup>	Joint UN/UNFPA	UN task team
	<ul style="list-style-type: none"> <li>• Morobe/AROB: no UNFPA support to health sector/FSC (MSF did it)</li> <li>• Enga FSC exists, no UNFPA support<sup>173</sup></li> </ul>		
<b>4. Sectoral responses to GBV</b>			
National level law enforcement response to GBV: <ul style="list-style-type: none"> <li>- develop police Training Manual on GBV &amp; Pre-Service curriculum on gender;</li> <li>- RPNGC to sensitize senior management on GBV</li> <li>- FSVAC develop reporting forms for FSVU</li> </ul>	<ul style="list-style-type: none"> <li>• 40 police trained '12</li> <li>• FSVAC training for police managers until '14 – several provinces<sup>174</sup></li> <li>• No reporting system/training/database<sup>175</sup> <ul style="list-style-type: none"> <li>• Reporting data: 15-25 per day per FSVU, increasing<sup>176</sup></li> <li>• Prosecution &lt;5%, arrested ±10%, IPO 65%<sup>177</sup></li> </ul> </li> <li>• No lawyers trained</li> </ul>	UNFPA/ UNDP	Gender
Provincial law enforcement response to GBV: <ul style="list-style-type: none"> <li>- FSVU train new recruits &amp; officers on GBV:</li> <li>- UNFPA baseline assessment on GBV reporting &amp; prosecution of GBV</li> </ul>	<ul style="list-style-type: none"> <li>• Training FSVU staff (#20 officers/training)</li> <li>• RPNGC training FSVU staff Central &amp; Enga (AROB not sure) ongoing<sup>178</sup></li> <li>• Central 1x (15), Morobe, Enga, AROB: Police training frontline officers done '16</li> <li>• AROB: FSVU received computer for reporting GBV etc. '16</li> <li>• Baseline not done</li> </ul>	With UNDP??	Gender
FSVAC community awareness on GBV, training of police officers, village court/district/court magistrate/lawyers on reporting and prosecution	<ul style="list-style-type: none"> <li>• FSVAC trainings for male opinion leaders (#30) on GBV prevention. #120 in all 4 priority provinces (and additional in other provinces) <sup>179</sup></li> </ul>	UNFPA	Gender
Youth response to GBV: <ul style="list-style-type: none"> <li>- FSVAC youth training on GBV prevention:</li> <li>- NYDA train in-school youth leaders on GBV</li> </ul>	<ul style="list-style-type: none"> <li>• FSVAC training for school students in NCD since '14<sup>180</sup></li> </ul>	UNFPA	Gender

<sup>173</sup> pers. comm. Betty Koka, ex UNFPA

<sup>174</sup> pers. comm. FSVAC

<sup>175</sup> pers. comm. FSVU Lae

<sup>176</sup> pers. comm. FSVU national coordinator

<sup>177</sup> pers. comm. FSVU national coordinator

<sup>178</sup> pers. comm. FSVU national coordinator

<sup>179</sup> pers. comm. FSVAC

<sup>180</sup> pers. comm. FSVAC

## ANNEX 6A – UNFPA PNG RESULTS FRAMEWORK 2012-2015

**National development priority (health):** strengthened primary health care for all and improved service delivery for the rural majority and for the urban disadvantaged National development priority (HIV/AIDS): reduce transmission of HIV and other sexually transmitted infections and minimize their impact on individuals, families and communities UNDAF outcome (access to basic services): an increased number of citizens have access to high-quality health and education services, leading to longer, healthier and more productive lives

**UNDAF outcome** (social justice, protection and gender equality): Papua New Guinea makes progress towards becoming a more inclusive and equitable society, where all citizens enjoy political, economic and social rights, free from discrimination and irrespective of gender, ethnicity or geographical isolation

Programme component	Programme component results	Key indicators, baselines and targets
Reproductive health and rights	<p>The capacity of the Government and relevant stakeholders is strengthened to improve the quality of, access to and utilization of maternal, newborn, child and adolescent health services, including services for sexual and reproductive health.</p> <p>The Government and its partners have strengthened their capacity to achieve the goals and strategic priorities of the national HIV/AIDS strategy.</p>	<p>Contraceptive prevalence rate (modern methods) among married women aged 15-49 years Baseline: 32%; Target: 40%</p> <p>Percentage of births attended by skilled health workers Baseline: 40%; Target: 50%</p> <p>Referral rate for emergency obstetric support Baseline: 5%; Target: 10%</p> <p>Age Specific Fertility Rate for women age 15-19 yrs Baseline: 65/1000; Target: 60 per 1000</p> <p>Percentage of men and women aged 15 to 59 who had more than one sexual partner in the past 12 months who report the use of a condom during last intercourse Baseline 38.9%; Target 50%</p>



**National development priorities:** (a) a high-quality national statistical service for development planning, policy formulation, decision-making and research through the production of accurate, comprehensive and timely statistics that meet international standards; and (b) an advanced stage of foreign-aid management and the eventual independence from foreign aid

**UNDAF outcomes** (governance for equitable development): (a) the Government will realize significant improvements in good governance, the leadership of development processes, budgeting and the financial management of service delivery, making optimum use of available resources to achieve local Millennium Development Goal targets; and (b) Papua New Guinea becomes a safer, more secure and stable nation, where citizens can make real strides towards sustainable development

<b>Programme component</b>	<b>Programme component results</b>	<b>Key indicators, baselines and targets</b>
Population and development	Relevant government bodies engage in data-based, evidence-based and participatory policymaking, planning and budgeting to achieve, with equity, the Millennium Development Goals.	<p>Percentage of annual, operational plans of health, education and community development departments that utilize key demographic data (relating to size, population growth rate, age, gender composition and spatial distribution) Baseline: 0%; Target: 100%</p> <p>Number of census and survey data sets disaggregated by age, sex and location that are utilized for decision-making at national and provincial levels Baseline: 1 (2006 demographic and health survey); Target: 3</p> <p>Percentage increase in the national budget allocated to sectors (health, education, community development and HIV/AIDS) that are directly linked to Millennium Development Goals 3, 5 and 6 Baseline: 0; Target: 20% increase</p>
Programme coordination and assistance	UNFPA country office has strengthened capacity for programme coordination, monitoring and evaluation	

**National development priority:** make significant progress towards gender equality and women's empowerment

**UNDAF outcome** (social justice, protection and gender equality): Papua New Guinea makes progress towards becoming a more inclusive and equitable society, where all citizens enjoy political, economic and social rights, free from discrimination and irrespective of gender, ethnicity or geographical isolation.

<b>Programme component</b>	<b>Programme component results</b>	<b>Key indicators, baselines and targets</b>
Gender equality	Women, men, boys and girls have increased opportunities to access resources, rights and decision-making processes through equal participation and benefits from the economic, social and political development of Papua New Guinea.	<p>Percentage reduction in the number of women aged 15-49 years who have experienced any form of violence in the last 12 months Baseline: to be determined; Target: 5% reduction</p> <p>Percentage of cases of gender-based violence that were reported to the police and that have been prosecuted Baseline: 0%; Target: 5%</p> <p>Percentage of trained advocates who have advocated the prosecution of gender-based violence cases Baseline: 0; Target: 50%</p> <p>Percentage of married women (aged 15-49 years) made jointed decisions with their partners in deciding the number and spacing of their children Baseline: to be determined; Target: increase by 20%</p>

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**ANNEX 6B – UNFPA PNG RESULTS FRAMEWORK 2016-2017**


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**UNDAF Outcome #1: The capacity of the Government and relevant stakeholders is strengthened to improve the quality of, access to and utilization of maternal, newborn, child and adolescent health services, including services for sexual and reproductive health.**

**Outcome Indicator 1:** Contraceptive prevalence rate (modern methods) among married women aged 15-49 years.  
Baseline: 32%; Target: 40%

**Outcome Indicator 2:** Percentage of births attended by skilled health workers.  
Baseline: 40%; Target: 50%

**Outcome Indicator 3:** Referral rate for emergency obstetric support.  
Baseline: 5%; Target: 10%

**Outcome Indicator 4:** Percentage of service delivery points with seven life-saving maternal/reproductive health medicines from the WHO priority list.  
Baseline: 62% (DHS) Target: 90%

<b>UNFPA Strategic Plan Outcome</b>	<b>New or existing CP Output(s) requiring additional resources for the extension period</b>	<b>Indicators, Baseline, Target</b>
<p><b>Outcome 1:</b> Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access</p>	<p><b>Output 1 [SP Outcome 1, Output 2]:</b> Increased national capacity to strengthen enabling environments for increased demand for and supply of modern contraceptives and improve quality family planning services that are free of coercion, discrimination and violence.</p>	<p><b>NEW Output 1 Indicator 1:</b> Percentage increase of National Health Budget allocated to sexual and reproductive health. Baseline: USD 1.3 million (2014); Target: At least a 5% increase by 2017</p> <p><b>NEW Output 1 Indicator 2:</b> National-level functional logistics management information system for forecasting and monitoring reproductive health commodities in place. Baseline: No; Target: Yes, by 2017</p> <p><b>NEW Output 2 Indicator 1:</b></p>

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**Output 2 [SP Outcome 1, Output 3]:** Increased national capacity to deliver comprehensive maternal health services.

Number of trained midwives in accordance to international standards that have capacity to assist in safe deliveries in UNFPA supported provinces. Baseline: 40; Target: 100

**NEW Output 2 Indicator 2:** EMOC comprehensive survey conducted with information resulting from it used for effective health systems strengthening and development of a costed national action plan to scale-up maternal and newborn health services. Baseline: No; Target: Yes

**NEW Output 2 Indicator 3:** Number of Provinces with a functional system for maternal death surveillance and response in place. Baseline: 6; Target: 12, by 2017

**Output 3 [SP Outcome 1, Output 4]:** Increased national capacity to deliver HIV programmes that are free of stigma and discrimination, consistent with the UNAIDS unified budget results and accountability framework (UBRAF) commitments.

**NEW Output 3 Indicator 1:** Number of community-based sex worker-led organizations who have participated in the design, implementation, and monitoring of programmes that address HIV and sexual and reproductive health needs of sex workers. Baseline: 1; Target: 2

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**UNDAF Outcome #2: The Government and its partners have strengthened their capacity to achieve the goals and strategic priorities of the national HIV/AIDS strategy.**

Indicator: Percentage of men and women aged 15 to 59 who had more than one sexual partner in the past 12 months who report the use of a condom during last intercourse.

Baseline 38.9%; Target 50%

**UNFPA Strategic Plan Outcome**

**New or existing CP Output(s) requiring additional resources for the extension period**

**Indicators, Baseline, Target**

**Outcome 2:** Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health

**Output 1 [SP Outcome 2, Output 7]:** Increased national capacity to design and implement community and school based comprehensive sexuality education (CSE) programmes that promote human rights and gender equality.

**NEW Output 1 Indicator 1:** Implementation of national comprehensive sexuality education curricula is aligned with international standards.  
Baseline: 0; Target: 1

**UNDAF Outcome #3:** Women, men, boys and girls have increased opportunities to access resources, rights and decision-making processes through equal participation in and benefits from the economic, social and political development of Papua New Guinea.

**Outcome Indicator 1:** Percentage reduction in the number of women aged 15-49 years who have experienced any form of violence in the last 12 months.  
Baseline: to be determined; Target: 5% reduction

**Outcome Indicator 2:** Percentage of cases of gender-based violence that were reported to the police and that have been prosecuted.  
Baseline: 0%; Target: 5%

**Outcome Indicator 3:** Percentage of trained advocates who have advocated the prosecution of gender-based violence cases.  
Baseline: 0; Target: 50%

**Outcome Indicator 4:** Percentage of married women (aged 15-49 years) who have made joint decisions with their partners in deciding the number and spacing of their children.

Baseline: to be determined; Target: increase by 20%

UNFPA Strategic Plan Outcome	New or existing CP Output(s) requiring additional resources for the extension period	Indicators, Baseline, Target
<p><b>Outcome 3:</b> Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth</p>	<p><b>Output 1 [SP Outcome 3, Output 9]:</b> Strengthened international and national protection systems for advancing reproductive rights, promoting gender equality and non-discrimination and addressing gender-based violence.</p> <p><b>Output 2 [SP Outcome 3, Output 10]:</b> Increased capacity to prevent gender-based violence and harmful practices and</p>	<p><b>NEW Output 1 Indicator 1:</b> Percentage of health program managers trained on gender mainstreaming. Baseline: 20; Target: 40</p> <p><b>NEW Output 1 Indicator 2:</b> National Council of Women restructured and operational with an office, technical staff and Annual General meeting (AGM). Baseline: Current restructuring Target: Status of an operational office, technical officers and AGM</p> <p><b>NEW Output 2 Indicator 1:</b> Number of legislations and policies enacted on Gender</p>

enable the delivery of multisectoral services, including in humanitarian settings.

Equality and Women's empowerment.  
Baseline: 2 (Draft Gender Equality and Participation Bill and Gender Policy). Target: 4

**NEW Output 2 Indicator 2:** Number of Provinces that have functional men's desks to promote men and boys as partners in prevention of GBV.  
Baseline: 4; Target: 12

**UNDAF Outcome #4:** Relevant government bodies engage in data-based, evidence-based and participatory policy making, planning and budgeting to achieve, with equity, the Millennium Development Goals.

**Outcome Indicator 1:** Percentage of annual, operational plans of health, education and community development departments that utilize key demographic data (relating to size, population growth rate, age, gender composition and spatial distribution).  
Baseline: 0%; Target: 100%

**Outcome Indicator 2:** Number of census and survey data sets disaggregated by age, sex and location that are utilized for decision-making at national and provincial levels.  
Baseline: 1 (2006 Demographic and Health Survey); Target: 3

**Outcome Indicator 3:** Percentage increase in the national budget allocated to sectors (health, education, community development and HIV/AIDS) that are directly linked to Millennium Development Goals 3, 5 and 6.  
Baseline: 0; Target: 20% increase

UNFPA Strategic Plan Outcome	New or existing CP Output(s) requiring additional resources for the extension period	Indicators, Baseline, Target
<p><b>Outcome 4:</b> Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development,</p>	<p><b>Output 1 [SP Outcome 4, Output 12]:</b> Strengthened national capacity for production and dissemination of quality disaggregated data on population and development issues that allows for mapping of demographic disparities and socio-economic inequalities, and for programming in humanitarian</p>	<p><b>NEW Output 1 Indicator 1:</b> National Statistics Office's population-based data available to users through a web-based platform that facilitates mapping of socio-economic and demographic inequalities. Baseline: Website-based platform not in place</p>

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sexual and reproductive health and reproductive rights, HIV and gender equality	settings.	and not accessible. Target: Website-based platform in place and accessible to the public by 2017.
<b>UNFPA Strategic Plan Outcome</b>	<b>New or existing CP Output(s) requiring additional resources for the extension period</b>	<b>Indicators, Baseline, Target</b>
Organizational Effectiveness and Efficiency Output	<b>Programme coordination and assistance:</b> UNFPA country office has strengthened capacity for programme coordination, monitoring and evaluation.	

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## ANNEX 7 - FIELD PHASE, UNFPA COUNTRY PROGRAM EVALUATION PAPUA NEW GUINEA 12 – 30 SEPTEMBER 2016

Date	Activity
Sun 11/10	Arrival team leader
Mon 12/10	CPE team planning meeting Briefing UNFPA Evaluation Manager
Tue 13/10	Briefing UNFPA Country Representative Presentation UNFPA programs and progress, UNFPA Country Team (all day)
Wed 14/10	Interview Marie Stopes International, implementing partner Interview University of PNG, implementing partner Interview WHO, UNDAF Health Task Team Chair Interview National Council of Women, implementing partner
Thu 15/10	Interview UN Resident Coordinator Interview National Department of Health team, counterpart Interview National Statistics Office, counterpart Interview UN Women, UNDAF Gender Task Team chair Meeting Evaluation Reference Group to finalize design report
Fri 16/10	Interview UNFPA Country Representative Documentation review
Sat 17/10	Documentation review
Sun 18/10	Travel Port Moresby to Bougainville
Mon 19/10	Interview Bougainville Women's Federation Focus Group Discussion Buka Family Support Center, Hospital Interview UNDP Office Bougainville Interview Bougainville Department for Community Development, counterpart Interview Buka Police, Family and Sexual Violence Unit, implementing partner
Tue 20/10	Focus Group Discussion Youth, participants youth training Interview CEO Bougainville Health Department
Wed 21/10	Travel Buka-Port Moresby - Lae
Thu 22/10	Interview Morobe Provincial Health Office Focus Group Discussion Morobe PHO team Focus Group Discussion participants Family Planning Training Interview and visit MSI clinic Lae, implementing partner Interview Lae Police, Family & Sexual Violence Unit
Fri 23/10	Interview Morobe Department for Community Development & FSVAC Interview Morobe Area Medical Store, implementing partner
Sat 24/10	Travel Lae-Port Moresby
Sun 25/10	Documentation review
Mon 26/10	Interview IPPF/PNG Family Health Association, implementing partner Interview National Youth Development Authority, implementing partner Interview World Vision Australia, implementing partner Interview Safe Motherhood Alliance, implementing partner Interview CEO Enga Provincial Health Office
Tue 27/10	Interview Reproductive Health Training Unit, partner Interview Royal PNG Constabulary (Family Sexual Violence Unit), counterpart Interview YWCA, implementing partner

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Date	Activity
	Interview Family Sexual Violence Action Committee, implementing partner Interview UNICEF
Wed 28/10	Interview Betty Koka, ex-UNFPA program manager Interview UNAIDS, Chair UNDAF HIV Task Team Interview Australia Dept of Foreign Affairs and Trade, UNFPA funder Port Moresby General Hospital (PMGH)
Thu 29/10	Interview Department National Planning and Monitoring Data analysis & preparation validation workshop (all day)
Fri 30/10	Validation Workshop with key informants and UNFPA team Debriefing to UNFPA management
Sat 1/10	Departure team leader

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