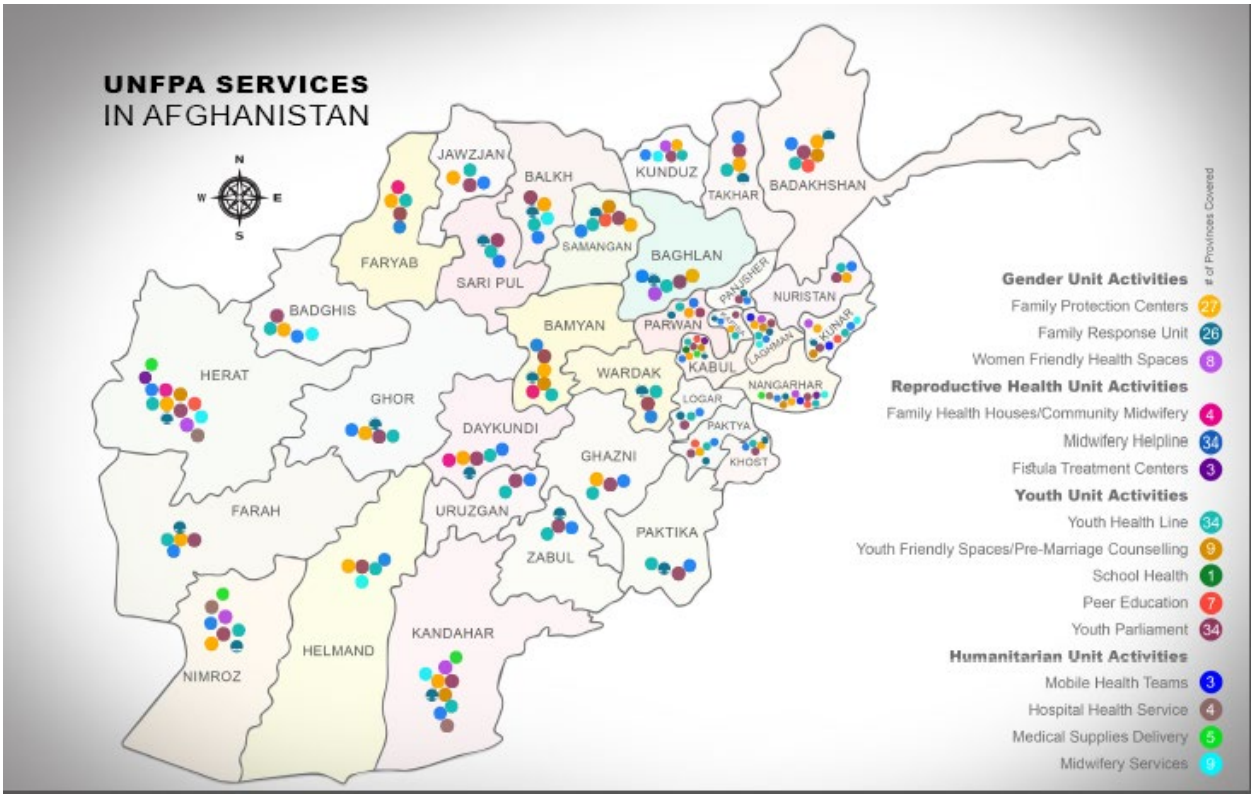
UNFPA AFGHANISTAN

4TH Country Programme 2015 – 2021

FINAL EVALUATION REPORT

May 2021

Map of Afghanistan[1]



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[1] The boundaries and names shown and the designations used on the maps on this site do not imply official endorsement or acceptance by the United Nations Population Fund.

Acknowledgement

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We appreciate the participation of members of the Evaluation Reference Group, especially those who took time to provide comments towards improving the quality of the CPE design and report. We would also like to acknowledge the contributions made by the UNFPA CO staff and stakeholders, without whom the CPE would not have been successful. The information provided, despite other commitments, was very useful in enriching this report and providing feedback to the CO.

The Evaluation Team hope that the findings and recommendations presented in this report will positively contribute to building a sound foundation for the development of 5th UNFPA Afghanistan country programme, national development plans and UNSDCF in Afghanistan.

Table of Content

ABBREVIATIONS AND ACRONYMS

AADA	Agency for Assistance and Development of Afghanistan
ACBAR	Agency Coordinating Body for Afghan Relief and Development
ACTD	Afghanistan's Centre for Training Development
AFGA	Afghan Family Guidance Association
AIHRC	Afghanistan Independent Human Rights Commission
ALCS	Afghanistan Living Conditions Survey
AMA	Afghan Midwifery Association
ANDMA	Afghanistan National Disaster Management Authority
ARH	Adolescent Reproductive Health
ANPDF	Afghanistan National Peace and Development Framework
APRs	Annual Planning Reports
ARCS	Afghan Red Crescent Society
ASDGs	Afghanistan Sustainable Development Goals
AWPs	Annual Work Plans
A&Y	Adolescents and Youth
BPHS	Basic Package of Health Services
CBA	Childbearing Age
CO	Country Office (UNFPA)
COVID-19	Corona Virus Disease - 2019
CPAP	Country Programme Action Plan
CP	Country Programme
CPD	Country Programme Document
CPE	Country Programme Evaluation
CRVS	Civil Registration and Vital Statistics
CPR	Contraceptive Prevalence Rate
CHW	Community Health Worker
CSO	Central Statistical Office
DFID	Department of International Development
DMT	WHO Decision-Making Tool

DMOYA	Deputy Minister of Youth Affairs
EQ	Evaluation Questions
ERG	Evaluation Reference Group
EU	European Union
FGD	Focus Group Discussion
FRU	Family Response Unit
FLE	Family Life Education
FHH	Family Health House
FP	Family Planning
GAC	Global Affairs Canada
GBV	Gender Based Violence
GDP	Gross Domestic Product
GE	Gender Equality
GEWE	Gender Equality and Women's Empowerment
GIIS	Gender Inequality Survey
GII	Gender Inequality Index
GoIRA	Government of the Islamic Republic of Afghanistan
GPS	Global Program System
HCT	Humanitarian Coordination Team
HDI	Human Development Index
HEWAD	HEWAD Reconstruction, Health and Humanitarian Assistance Committee
HWG	Health Working Group
HNTPO	Health net Psychosocial Organization
IADC	Italian Agency for Development Cooperation
ICPD	International Conference on Population and Development
IEC	Information Education Communication
IDB	International Development Bank
IDMC	Internal Displacement Monitoring Centre
IMC	International Medical Corps
IUCD	Intra-Uterine Contraceptive Device

IOM	International Organization for Migration
IP	Implementing Partner
LARC	Long Acting Reversible Contraceptives
LMIS	Logistics Management Information System
LDC	least developed country
LRP	Learning resource package
KII	Key Informant Interviews
KU	Kabul University
MDG	Millennium Development Goals
MHT	Mobile Health Teams
MoI	Ministry of Interior
MNDSR	Maternal and Newborn Deaths Surveillance and Response
MoPH	Ministry of Public Health
MOVE	MOVE Welfare Organization
MISP	Minimum Initial Service Package
MPI	Multidimensional Poverty Index
NEET	Not in Employment, Education or Training
NSIA	National Statistics and Information Authority
NTA	National Technical Assistants
NGO	Non-governmental Organization
NPP	National Priority Programs
OECD/DAC	Organization for Economic Cooperation and Development
OHCHR	Office of High Commissioner for Human Rights
OF	Obstetric Fistula
PCA	Programme Coordination and Assistance
PD	Population dynamics
P&D	Population and Development
PDS	Population and Development Strategies
PO	Programme Officer
RHCS	Reproductive Health Commodities Security

RRF	results and resources framework
RH	Reproductive Health
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SBCC	social behaviour change communication
SDES	Sociodemographic and economic survey
SIS	Strategic Information System
RH	Reproductive health
RHR	Reproductive Health and Rights
ToC	Theory of Change
ToR	Terms of Reference
TPM	Third Party Monitoring
UNAMA	United Nations Assistance Mission in Afghanistan
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Program
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Emergency Children Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
USAID	United States Agency for International Development
WFP	World Food Programme
WHO	World Health Organization
YHL	Youth Health Line
YHC	Youth Health Corners
YHDO	Youth Health and Development Organization

Afghanistan Key Facts

Indicators	Facts (Data Value)	Source/ Year
Land		
Geographical location	South Asia	World Bank
Surface area	652,230 Sq. Km	World Bank
People		
Population (2020)	32,890,171 (est.)	Flowminder/NSIA/UNFPA (2019)
Population aged below 15 years	47% (est.)	National Statistics and Information Authority, NSIA, (2019)
Population aged 15 – 24 years	20% (est.)	NSIA (2019)
Population aged below 30 years	75% (est.)	NSIA (2019)
Population aged 65 years and above	2.7% (est.)	NSIA (2019)
Women of reproductive age (15 – 49)	20% (est.)	MoPH HMIS (2019)
Urban population	24.3% (est.)	NSIA (2019)
Rural population	71% (est.)	NSIA (2019)
IDPs	2,993,000	IDMC (2019)
Population growth Rate	2.4%	World Bank (2018)
Health		
Infant mortality rate (deaths per 1'000 live births)	47.86 (est.)	IGME (2019)
Neonatal mortality rate (deaths per 1'000 live births)	37.1 (est.)	IGME (2019)
Under-5 mortality (deaths by 1'000 live births)	62.28 (est.)	IGME (2019)
Adolescent fertility rate (per 1'000 women	65.14	World Bank (2018)
Contraceptive prevalence rate (% of women aged 15-49)	22.5%	AfDHS (2015)
Unmet need for contraceptive use	24.5%	AfDHS (2015)
Maternal Mortality ratio (per 100'000 live births)	638 (modelled)	World Bank (2017)
Life expectancy at birth	64.49 years	World Bank (2018)
Total fertility rate (average number of children per woman)	5.1	AHS (2018)
Adults aged 15-49 HIV prevalence rate	0.1%	World Bank (2018)
Proportion of births attended by skilled health personnel	58.8	AHS (2018)
Total of Health Expenditure (% of GDP)	12.7 %	National Health Account 2018
Government		
Type of government	Presidential	Afghanistan Constitution
Head of government	President	Afghanistan Constitution
Economy		
GDP	$19.10 billion	World Bank
GDP annual growth rate	2.9 %	World Bank
Per capita income	$502.1	World Bank
Unemployment rate	24%	ALCS (2017)
Youth unemployment rate	17.43% (est.)	ILO (2019)
Multidimensional Poverty Index	0.272	UNDP HDI report 2019
Social and Development Indicators		
Human Development Index rank	170 (0.496)	UNDP HDI report 2019
Literacy rate	43.02%	World Bank (2019)
Net enrolment in Primary school	104%	UNESCO (2018)
Net enrolment in secondary school	55.43%	UNESCO (2018)
Gender Inequality Index	0.575	UNDP HDI report 2019
Seats held by women in national parliament	27.4 % of the total seats	UNDP HDI report 2019
Women experienced GBV (Percentage of ever-married women aged 15-49 who have ever experienced emotional, physical or sexual violence committed by their husband)	56%	AfDHS 2015
Prevalence of teenage marriage (proportion of women aged 15-19 years who were married or in a union)	3% male, 17% Female	AfDHS 2015

STRUCTURE OF THE COUNTRY PROGRAMME EVALUATION REPORT

This Country Programme Evaluation Report is structured according to the UNFPA Evaluation Handbook. Chapter One introduces the purpose and objectives of the Country Programme Evaluation, outlines its scope as well as the methodology and processes. Chapter Two, describes the programme implementation context, highlighting the development challenges, in addition to the national strategies, and the role of external assistance. Chapter Three describes the UN and UNFPA strategic response as well as the UNFPA response through the current 4th CP and previous 3rd CP country programmes.

Chapter Four presents the findings of the CPE guided by the evaluation questions under each evaluation criteria of relevance, effectiveness, sustainability, efficiency, coordination, Coverage and Connectedness. Chapter Five covers the conclusions to the report presented at both strategic and programmatic levels; and the Lessons learnt. Chapter Six provides the CPE recommendations and are also presented at strategic and programmatic levels. Prior to the main chapters the report includes acknowledgements, acronyms and abbreviations, the list of tables and figures, a key facts table and an Executive Summary. Finally, the report provides the following annexes: Terms of reference, list of persons/ institutions visited and interviewed, documents reviewed, evaluation matrix, the CPE agenda and stakeholders map.

EXECUTIVE SUMMARY

Purpose, Scope and intended audience: This report presents the process, findings, conclusions and recommendations of the Cooperation Government of the Islamic Republic of Afghanistan and UNFPA 4th programme cycle (2015 – 2021) Country Programme Evaluation (CPE). The purpose of the evaluation serves three primary purposes: (i) demonstrate accountability to stakeholders on performance in achieving development results and on invested resources, (ii) support evidence-based decision-making, and (iii) contribute important lessons learned to the existing knowledge base on how to accelerate the implementation of the Programme of Action of the International Conference on Population and Development (ICPD) and support the achievement of SDGs. Specifically, the CP aimed to; provide an independent assessment of the relevance, effectiveness, efficiency, and sustainability of UNFPA support and progress towards the expected outputs and outcomes of the 4th CP in the changing development and humanitarian contexts; analyse expected, and unexpected results, challenges, and lessons learned of the CP4 implementation; provide an assessment of the CO's strategic positioning within the development and humanitarian communities, including within the UNCT and national partners, and comparative advantage; draw key lessons from past and current cooperation and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the next programming cycle; and review the design of the Country Programme including management, operations, coordination, and partnership arrangements. The scope of the CPE covered the period from 2015 up to October 2020, including the CP four outcomes and all the provinces covered by the 4th CP. The intended audience for the CPE report will be decision-makers in UNFPA (at country office and relevant regional and HQ units), Government of Afghanistan; donors; civil society, private sector, and the UN agencies.

The 4th Country Programme: The 4th Country Programme was designed in alignment with the National Development Plan, the 2030 Agenda for Sustainable Development (particularly Goals 3, 5, 10 and 17), and the United Nations Development Assistance Framework (UNDAF) 2015-2019; and later One-UN Accountability Framework (2018 – 2021) focusing on four thematic outcome areas Reproductive Health and Rights (RHR), Adolescent and Youth (A&Y), Gender Equality and Women's Empowerment (GEWE), and Population Dynamics (PD). The programme contributed to the reduction of maternal mortality in Afghanistan, especially among the marginalized and hard-to-reach populations; ensured increased social equity of women, youth and minorities and vulnerable populations; and increased national capacities to conduct evidence-based advocacy for the rights and needs of adolescents and youth; as well as targeting those in the humanitarian settings. The programme emphasised strengthening the capacities of the national stakeholders to improve RHR, A&Y, GEWE and PD indicators in the country, utilizing all the five modes of engagement: advocacy and policy dialogue; capacity development; knowledge management; partnership and coordination, and service delivery.

CPE Methodology: The design of the CPE was guided by the UNFPA Evaluation Handbook on how to conduct a country programme evaluation[2], in addition to the formats of the design and evaluation reports. The CPE was a theory-based non-experimental design using a participatory approach, and guided by a set of 10 questions corresponding to the evaluation criteria mentioned earlier.

[2] Evaluation Handbook: How to Design and Conduct a Country Programme Evaluation at UNFPA, 2019

The consultants used a purposive sampling method to select participants for the CPE. The stakeholder selection process was guided by the thematic areas of engagement with UNFPA of the IPs, and financially large and small programmes and projects; partners from government and civil society organisations (CSOs), donors, strategic partners and, direct and indirect beneficiaries. The CPE adopted mixed methods in data collection, namely; i) Document review; ii) remote-based and face-to-face key informant interviews (KIIs) at group and individual levels with the selected stakeholders and CO staff conducting a total of 43 sessions; iii) Focus group discussions with stakeholders and beneficiaries conducting three sessions; and d) three selected site visits. Triangulating the sources and methods of data collection, evaluation used both qualitative and quantitative data in the analysis and generation of the evaluation report. The data were collected using both face-to-face and virtually due to COVID-19 restrictions through Zoom, Google Meet platforms and teleconference with direct and indirect beneficiaries. Ethics and quality control requirements were adhered to by the consultants and assured by the Evaluation Manager. There were no major challenges encountered during the field phase, and the purpose and objectives of the CPE were fully met with invaluable support from the CO team.

Main Conclusions: The 4th Afghanistan Country Programme was strategically aligned with national and international development priorities, as expressed in the Afghanistan National Development Strategy 2008-13, Afghanistan National Peace and Development Framework (ANPDF), National Priority Programmes, the One-UN 2018-2021, International Conference on Population and Development, and the UNFPA Strategic Plans, 2014 – 2014 and 2018-2022 and is contributing to the Sustainable Development Goals (SDGs). There was responsiveness in the programme implementation towards humanitarian and emerging needs, occasioned by changes in the implementation context, especially conflicts leading to displacement, drought, floods, and returnee influx during the 4th CP implementation period. There was evidence of high level consultations during design and implementation with the government and various stakeholders, advancing national ownership and capacity building. UNFPA Afghanistan clearly added value to addressing national development needs in Reproductive health, for adolescents and youth, and in population data, and in responding effectively to humanitarian situations in the country. At the national level engagement, UNFPA continued the strategy of prioritising areas of need, especially with poorer RH indicators, and mainstreamed gender and a human rights focus, for instance addressing gender based violence (GBV), treatment for fistula survivors and child marriage. UNFPA Afghanistan also strengthened GBV prevention and response, including elimination of harmful practices in the country. In addition, the UNFPA's strength is recognized and depended upon in its areas of programme responsibility within the UNCT and contributes to its functioning through participating in the various joint programmes and collaborations enhancing coordination. There is however an opportunity to strengthen strategic partnership for ownership of the CP results, in addition to integration of the programme components to improve efficiency, effectiveness and sustainability.

Effectiveness: The CP achieved most of the output targets across the components, ensuring that the programme addressed the felt development and humanitarian needs in the areas of mandate in the county. Under **Reproductive Health and Rights (RHR)**, UNFPA contributed to strengthening of capacities of the health systems prioritizing access to Reproductive health and rights information and improved service delivery. UNFPA strengthened the capacities of the national stakeholders in delivering quality Reproductive Maternal Neonatal Child Adolescent Health (RMNCAH). The CO contributed to improving evidence-based family planning programming through development of Costed Implementation Plan for family planning, development of guide social behaviour change (SBCC) strategy; in addition to strengthening the capacities of healthcare workers on administration of family planning methods. The CO also enhanced access to skilled birth attendance in the country through financially and technically supporting midwifery education and deploying them, midwifery association and nursing and midwifery council; supporting review of the midwifery curriculum to the International Conference of Midwives/WHO standards, and incorporating FP; establishment of family health houses (FHH) and equipping them to deliver RH services, in the remote and marginalized hard-to-reach areas in Afghanistan. During

the period, UNFPA enhanced the capacities of the county in the treatment of obstetric fistula, in addition to supporting integration of the survivors into their communities. Towards strengthening institutional capacities, UNFPA technically and financially supported development of strategies, guidelines, tools and standard operating procedures (SOPs) to guide service delivery, in addition to support supervision and mentorship of the health workers. Further, the CP contributed to strengthening service delivery and policy framework through facilitating and coordination development of RMNCAH advocacy strategy and guidelines, MDSR strategy and training of healthcare workers, Logistic management information system (LMIS) Policy and related tools. There were however gaps in the SOPs and guidelines implementation, due to inadequate capacity and commitment of the government authorities and among the healthcare workers. On Family planning, the deeply-rooted socio-cultural beliefs, myths and misconceptions, in addition to unavailability of long-term family planning methods are playing a role in hampering use.

Under the **Adolescent and Youth** component, UNFPA's technical and financial support of DMoYA in the development of the National Youth Strategy and National Youth Policy provided a framework for increased targeting of the youth in the country, enhancing their empowerment and greater involvement in decision-making, in addition to opening up more opportunities for the youth in the country. Implementation of the strategy and policy is however slow due to inadequate funds allocation and weak coordination among the seven ministries involved in its implementation. The 4th CP contributed to amplifying the relevance and importance of the youth participation in governance and state building through the youth parliament activities. Further, the programme enhanced access to adolescent and youth reproductive and rights (ARHR) services in the country through establishment of youth-friendly facilities and provision of services and capacity strengthening of providers. Piloting of the pre-marriage counselling was a great contribution in enhancing family cohesion, values and improving access to their reduction rights and decision-making.. During the period of review, UNFPA facilitated the review of Family Life Education, but this did not get integrated into the school curriculum due to weak coordination between Ministries of Public Health and Education. Further, inadequate fund allocation to the component limited level of engagement, especially Youth Parliament activities could not continue because of inadequate funds.

There were great improvements made towards strengthening **gender equality and women's empowerment (GEWE)** in the country during the 4th CP through strengthening policy, legal, and accountability mechanisms, transformation of attitudes, values, norms that perpetuate GBV, and, child marriage, and provision of services to GBV survivors. UNFPA further promoted reproductive rights and women's empowerment through engagement of duty bearers and rights holders facilitating contributing to elimination of behaviours that disenfranchise women and girls among the target population. The establishment of the family protection centres (FPCs) in 22 provinces facilitated access to health services by the GBV survivors, in addition to psychosocial and legal support; and referrals for further access to justice. The strengthening of the capacity the police through support to the family response units (FRUs) and integration of GBV prevention and response was a great contribution of the 4th CP enhancing survivor support. UNFPA also enhanced synergies and leveraging of resources, partnerships for prevention and response to GBV in the country through technically and financially supporting and leading the GBV sub-cluster coordinating. UNFPA, together with UN women enhanced gender mainstreaming across the UNCT; in addition to supporting GBV Information Management System (GBV IMS) for evidence-based programme and streamlining response. Weak referral pathways, non-existent law in the penal code penalising GBV and practice of harmful practices hinder response, disjointed response, absence of legislation, and deeply-rooted social and cultural beliefs inhibit response.

Implementation of the **Population Dynamics** component interventions contributed to strengthening evidence-based planning and development through financial and technical support to the NSIA, Kabul University and the respective ministries in generation, analysis and dissemination of population-based information. The implementa-

tion of the sociodemographic and economic surveys (SDES) enhanced UNFPA strengthened national statistics capacity in survey design, collection, analysis and report writing on RH, adolescents and youth, gender and population dynamics enabling mapping of inequalities and informing interventions during humanitarian crisis. In addition, the SDES enabled evidence-based planning and monitoring of development in the nine provinces they were conducted, as well as generation of key indicators for monitoring the localized Sustainable Development Goals (SDGs) and contributed to International Conference on Population and Development (ICPD) goals. There was increased dissemination and access to information for decision-making at the provincial level through the establishment of data corners.

The introduction of the use of high resolution satellite imagery to estimate population data and other development indicators through UNFPA's support and facilitation was one-of-its kind, further addressing population and social information access gaps in the country due to insecurity and inadequacy of resources. Through south-south cooperation and strategic partnership with Kabul University, UNFPA contributed to enhancing the strengthening of institutional capacity in statistics and demography enhancing long-term capacities for data generation and utilization for development. UNFPA supported the development of the National Population Policy, which will enhance evidence-based decision-making in development and programme management. Utilization of generated data is a huge gap in Afghanistan and may need to be strengthened in order to realize evidence-based policy planning and formulation. Budget cuts experienced by the component during the period, in addition to insecurity hindered completion of the SDES.

Under **efficiency**, there was evidence of efficient use of human, financial, technical and administrative resources towards achievement of the 4th CP results. The CO had adequate and skilled staff in all the programme and administrative areas and largely followed the laid down guidelines in procurement of services and materials. There was significant achievement in utilisation of funds across the first five programme period covered in the CPE. The rates were however affected by late disbursement of funds from some of the donors. UNFPA nurtured different partnerships, including South – South Cooperation, and technical assistance, which facilitated implementation of the programme to ensure efficiency, and delivering more results. The strategic partnership with the government, within the UN and donors ensured favourable implementation framework, leveraged synergies and funding opportunities for the CO. The partnership with the implementing partners, most of which were local NGOs facilitated wider geographical coverage, facilitating a wider reach and most of marginalized and hard-to-reach populations, enhancing efficiency. South-South cooperation facilitated through UNFPA greatly enhanced capacities in various components of the programme. UNFPA also supported the ministries with national technical assistance (NTAs) contributing to facilitation of the programme activities. It was however a challenge to establish the extent to which the NTAs contributed to building the capacities in the ministries, in addition to their contribution to the CP's efficiency. The monitoring and evaluation system was fairly robust, with clear processes and activities embedded in the programme management and delivery. High turnover among partner staff, especially the government, inadequate capacity and commitment of the government in monitoring and weaknesses in design of the CP in results areas. There is also room for improvement especially in terms of staff skills match with the job expectations, enhancing focus on results-based approaches, and enhancing programming in the context of COVID-19 for more reach and results.

The design, planning and execution of the 4th CP integrated **sustainability** measures. The 4th CP was developed through a consultative manner led by the government with the interventions contributing directly to the government plans and targets, enhancing national ownership of the intervention results, making it possible for the government to follow-up the actions after the CP support. In addition, the UNFPA CO implemented the 4th CP through the strategic partnership with the government line ministries, in addition to working with community structures while implementing

the programme and ensuring ownership of the results and interventions. The partnership with the local NGOs building trust into the community, enhancing support of the programme interventions and ownership of the CP results. UNFPA invested heavily in capacity building of the country in the various components, including policy and strategy development, guidelines, SOPs and tools development, in addition to enhancing skills transfer and institutional strengthening to enhance delivery of services. overdependence of the Afghanistan government on foreign aid, especially in the service provision, weak monitoring processes, inadequate commitment of the government, high staff turnover and inadequate funds threaten the possibility of sustainability.

UNFPA role in **coordination** and functioning of UNCT is significant and visible, with significant contribution in the functioning of the UNCT coordinating mechanisms building on the triple mandate of coordination, accountability and capacity building, and its contribution to the achievement of the One-UN Accountability Framework. UNFPA is an active participant and applied comparative advantage for the effective and efficient running of the UN coordination mechanisms. UNFPA contributed to strong linkages and synergies within the UNCT through joint programmes, in addition to collaborating with other UN agencies, especially in the humanitarian response, gender, adolescent and youth, and RH. There were however weaknesses in the coordination among UN agencies, especially in the humanitarian and health sectors, with some competition among the agencies, creating leading to conflicts.

The UNFPA humanitarian programme contributed to addressing the needs of the vulnerable populations through, partnerships, capacity building, integration, standardization of response, coordination and leveraging resources, and service mapping across the country. Through partnership with the Afghanistan Red Crescent Society (ARCS), the 4th CP reached and responded to all the humanitarian cases arising during the period, enhancing **coverage**. The 4th CP ensured **connectedness** through strengthening capacities of the actors, development of strategies, guidelines and policies to guide implementation, coordination and promoting integration of programmes and national ownership in the implementation processes, in addition to supporting development of preparedness plans. The protracted humanitarian situation in Afghanistan, coupled with weak institutions and governance systems, inadequate capacities, poor infrastructure and response systems, limits connectedness of the CP results.

Main Recommendations

Strategic level

I. Prioritize wide consultations to enhance strategic alignment of the 5th CP to the Afghanistan's national development and humanitarian priorities, as well as to the international and regional normative frameworks to respond to the country's needs and priorities, in addition to strengthening national and international partnerships in the development and humanitarian framework for effective delivery.

II. Enhance strengthening of capacities, including the implementing partners and within the CO itself to ensure evidence-based programming, while at the same time supporting advocacy mechanisms for increased resources allocation in the areas of Adolescent and youth, RHR, GEWE in development and humanitarian planning. In addition, encourage strengthening of institutional capacity building and policy formulation; financial planning mechanisms and broadening funding sources to cover funding gaps that arise due to donor situations and enhance sustainability.

III. UNFPA should maintain its proactive role in the functioning of the UNCT coordination and One-UN, explore opportunities for joint programming and advocate for more accountability among UN agencies

IV. UNFPA to reassess its institutional capacity, guided by the strategic positioning in the country, identify gaps, especially on human resources and implement the findings. Further, the 5th CP

needs to be premised on a ToC with clear changes underlying the results chain, in addition to prioritizing integration of the programme components for efficiency.

V. Prioritize capacity building, systems strengthening and community level engagement to facilitate humanitarian-development-peace nexus and resilience-building in the country. In the context of COVID-19, strengthen capacities of the community level stakeholders to take responsibilities for ensuring effective delivery of services, strengthen community structures, including government to enhance oversight role in the programme implementation processes and strengthen localized coordination mechanism among stakeholders in a particular locality for ease of coordinated response.

Programmatic level:

RHR:

I. Support the scale-up of strategies and interventions to address the unmet needs for Family Planning.

II. UNFPA should actively engage MoPH and donors to support midwifery capacity strengthening to increase access to skilled birth attendance. Key is to support integration of the FHH into the mainstream government health systems and increase resource mobilization efforts to enhance its expansion to the marginalized and hard-to-reach areas. Strengthen the capacity of the government to treat Obstetric Fistula survivors, in addition to supporting social integration for the fistula survivors.

Adolescent and Youth

III. Advocate for strengthened coordination among the National Youth Strategy and Policy implementing ministries, including development of a national action plan for the implementation of the same assigning roles and time lines for implementation of the key intervention areas. Further, advocate for resource allocation by the government for the implementation of the strategy and policy.

IV. UNFPA to strengthen partnerships and coordination to enhance capacities to increase integration of youth- and adolescent friendly RH information and services and reproduction rights. Strengthen mechanisms aimed at increased engagement and mainstreaming of youth participation and interventions in the country. There is also need to strengthen integration of FLE into the school curriculum.

GEWE:

V. Advocate for strengthened multisectoral coordination for and quality GBV service delivery, and advocacy for scale-up of policy and legislative framework on GBV response and prevention. In addition, there is need is need to strengthen case management mechanisms, including the referral pathways for GBV response.

VI. Strengthen community level advocacy on prevention of GBV and elimination of harmful practices among the targeted populations, including increasing focus on culturally sensitive approaches to address socio-cultural norms and evidence generation on GBV prevention and empowerment of women and girls. In addition, increase engagement of the duty bearers, especially the community and religious leaders, and men and boys in upholding the rights of the women and girls.

Population Dynamics

VII. UNFPA should enhance strengthening of accountability and commitment of the government and relevant agencies on integration of population dynamics into development and humanitarian response programme and policies' planning and monitoring.

VIII. Advocate for reinforcement in harmonization of data generation techniques, including embracing enhanced utilization of technology and innovation as a way of

addressing the unique contextual challenges in generation of data to address data gaps in the country.

CHAPTER 1: INTRODUCTION

The United Nations Population Fund (UNFPA), Afghanistan Country Office (CO) is currently implementing 4th cycle of the Government of the Islamic Republic of Afghanistan/ UNFPA Country Programme, which started in 2015 and planned to end in 2021. The country programme builds on the three previous UNFPA country programme cycles and is aligned with national priorities as reflected in the Afghanistan National Development Strategy 2017 – 2021 and national sectoral strategies. It is also aligned with the UNFPA strategic plans, 2014-2017 and 2018-2021, grounded on human rights and gender equality principles, incorporates Islamic values, and contributes to UNDAF and One UN for Afghanistan priorities[3]. It is implemented in partnership with the government of the Islamic Republic of Afghanistan.

The UNFPA Afghanistan Country Office commissioned the Country Programmes Evaluation (CPE) in compliance with the 2019 UNFPA Evaluation Policy[4]. The policy guided the design, management and governance of the CPE process, in addition to the the Norms and Standards, and Ethical Guidelines for Evaluators in the UN system and the Code of Conduct, established by the United Nations Evaluation Group (UNEG)[5]

1.1 Purpose and Objectives of the CPE

The purpose of this evaluation serves three primary purposes: (i) demonstrate accountability to stakeholders on performance in achieving development results and on invested resources, (ii) support evidence-based decision-making, and (iii) contribute important lessons learned to the existing knowledge base on how to accelerate the implementation of the Programme of Action of the International Conference on Population and Development (ICPD) and support the achievement of SDGs. Further. the CPE aimed at generating an independent assessment of successes, challenges, and lessons learned so that this can feed into the UNFPA new programme cycle.

Specifically, the objectives of the CPE were:

i. Provide an independent assessment of the relevance, effectiveness, efficiency, and sustainability, coverage and connectedness of UNFPA support and progress towards the expected outputs and outcomes of the 4th CP in the changing development and humanitarian contexts;
ii. Analyze expected, and unexpected results, challenges, and lessons learned of the CP4 implementation;
iii. Provide an assessment of the CO's strategic positioning within the development community, including within the UNCT and national partners, and comparative advantage;
iv. Draw key lessons from past and current cooperation and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the next programming cycle.
v. To review the design of the Country Programme including management, operations, coordination, and partnership arrangements;

The primary users of CPE will be decision-makers in UNFPA (at country office and relevant regional and HQ units), the Executive Board, and counterparts in the Government of Afghanistan. Additionally, partners among donors (Australia, Canada, EU, Korea, Japan, Italy, the United Kingdom), civil society, private sector, and other sister UN agencies (e.g. World Food Programme, [WFP], United Nations Children's Fund [UNICEF], World Health Organization [WHO]) are intended audience for the evaluation results.

1.2 Scope of the Evaluation

The CPE covered the period 2015 up to October 2020 and included all initiatives under the four outcomes and seven outputs of the 4th CP. The CPE covered all the provinces covered by UNFPA during the period of implementation period since 2015 to current in both development and humanitarian settings in the country.

1.3 Methodology and Process

[3] 4th Country Programme Document
[4] See https://www.unfpa.org/EvaluationHandbook
[5] See The UNFPA Afghanistan 4th Country Programme Evaluation Terms of Reference

1.3.1 Methodology

1.3.1.1 Evaluation Criteria and Evaluation Questions

The design of the CPE was informed by the UNFPA Evaluation Handbook "*How to design and conduct a CPE at UNFPA*" and covered the following four criteria of the Development Assistance Committee of the Organization for Economic Co-operation and Development (OECD/DAC): Relevance, Effectiveness, Efficiency and Sustainability[6]. In addition, the CPE also assessed the strategic positioning of UNFPA within the UNCT and the role it has played in United Nations system-wide coordination mechanisms. Further, given the humanitarian crises in Afghanistan, the evaluation has examined to what extent UNFPA has been able to provide life-saving services to affected populations that are hard to reach and how well UNFPA support bridges the humanitarian-peace-development nexus and contributes to enhancing resilience by examining the criteria of connectedness[7]. The CPE design took into consideration two levels of analysis, i.e. programmatic and strategic levels, where the four OECD-DAC evaluation criteria entailed analysis of UNFPA programmatic areas; and analysis of UNFPA's strategic positioning in the UNCT and the country's humanitarian implementation context (coverage and connectedness). Also included is addressing the cross-cutting issues of gender mainstreaming and a human rights approach integration into the programme. Table 1.1 show the evaluation question under each criteria.

Table 1.1: List of the Evaluation Questions

Evaluation Questions Under each criteria
Relevance – EQ1: To what extent is UNFPA support in the fields of RH and rights, youth development, population and development, and gender equality (i) adapted to the needs of the population, particularly of the most vulnerable and marginalized, ii) adapted to priorities or shifts caused by crisis or major political change and (iii) in line with the priorities set by the national policy frameworks? **EQ2:** To what extent is the Country Programme (2015-2019 and its extension to 2021) aligned to the UNFPA Strategic Plan 2018-2021 and One-UN Mutual Accountability Framework 2018-2021, and Sustainable Development Goals?
Effectiveness - EQ3: To what extent have the 4th CP outputs been achieved, and to what extent have these outputs contributed to the achievement of the 4th CP outcomes, including Humanitarian preparedness and response? **EQ4:** To what extent did the country programme integrate a gender-responsive and human rights-based approach to programme planning, implementation, and monitoring?
Sustainability – EQ5: To what extent has UNFPA been able to support its partners and the beneficiaries (women, adolescents and youth) in developing capacities and establishing mechanisms to ensure ownership and the durability of effects as well as established and maintained different types of partnerships across programme components during CP implementation and exit strategy UNFPA applied to ensure smooth transfer of its support to the national counterparts?
Efficiency - EQ6: To what extent has the CO made good use of its human, financial, technical and administrative resources, and has used an appropriate combination of tools and approaches to pursue the achievement of 4th CP outcomes promptly?
Coordination – EQ7: To what extent has the UNFPA CO contributed to the functioning and consolidation of UN Country Team (UNCT) coordination mechanisms?
Added Value – EQ8: What is the main UNFPA added value in the country context as perceived by national stakeholders?
Coverage – EQ9: To what extent has the UNFPA humanitarian response reached those most in need and vulnerable in crisis situations both geographically and demographically?
Connectedness – EQ10: To what extent does UNFPA humanitarian action support and plan for longer-term development goals articulated in the results and resources framework of the 2018-2020 Country Programme and contributed to resilience building?

1.3.1.2 Evaluation Approach

Evaluation Design: The CPE was conducted in accordance with the "Norms and Standards for Evaluation", "Ethical Guidelines for Evaluation", the "Code of Conduct for Evaluation in the United Nations System" and the "Guidance on Integrating Human Rights and Gender Equality in Evaluations of the United Nations Evaluation Group" (UNEG), and designed and implemented in consistency with the UNFPA Evaluation Handbook "How to design and conduct a CPE at UNFPA" and adhered to the standards and principles of evaluation at UNFPA, particularly utility, credibility, independence, impartiality, ethics, transparency, and human rights and gender equality. This was a non-experimental design given the expected descriptive and non-normative nature of the objectives and the related evaluation questions. This design was also relevant due to the time and resource constraints and it also allowed

[6] The OECD/DAC Criteria for International Development Evaluations https://www.oecd.org/dac/evaluation/49756382.pdf

[7] See The UNFPA Afghanistan 4th Country Programme Evaluation Terms of Reference.

the evaluators to analyse the contributory relationship between the programme interventions and their effects on the UNFPA programme's strategy in the Afghanistan context.

Theory-based approach: The CPE adopted a theory-based approach to assess the performance of the 4th UNFPA Afghanistan Country Programme. This entailed **reconstructing the theory of change (ToC)** underlying the Country Programme (see Figure 1.1) and the analysis of the causal links of the country programme interventions and strategies across the results chain. In the analysis of the ToC, the process established the mechanisms of change, considering the risks, critical assumptions and the implementation context underlying the programme logic. The evaluation team reviewed and redefined the theory of change, depicting the sequence of expected changes across the intervention logic of the country programme. The theory of change further illustrates how the planned interventions under the CP are expected to contribute to a sequence of results (outputs and outcomes) that contribute to the strategic goal of UNFPA, as defined in the UNFPA Strategic Plan 2018 – 2021.

matrix, in addition to reflecting the consideration in the analysis of the contextual implementation framework.

*Participatory approach***:** The CPE implementation based on an inclusive, transparent and participatory approach, involving a broad range of partners and stakeholders at national and sub-national levels. These stakeholders provided insights and information, as well as referrals to data sources that the evaluation required to assess the contribution of UNFPA and to answer the evaluation questions. Particular attention was paid to ensuring participation of women, adolescent girls and young people, especially those from vulnerable and marginalized communities. Further, the Evaluation Reference Group (ERG) established by the UNFPA Afghanistan CO for the CPE and comprises key stakeholders of the Country Programme also contribute to the process. The ERG also served in ensuring quality assurance from a technical perspective by providing inputs on evaluation deliverables at different stages of the evaluation process, including validation of initial findings during a stakeholders' review session, deliverables and consultation on the recommendations. In addition, the engagement of the ERG

The interpretation of the causation process guided the evaluators in understanding the programme's contribution to the observed results and in gathering evidence to validate the conclusions on the performance of the programme in the period of implementation. The ToC was tested during the data collection phase using the evaluation matrix and was reconstructed as stated in Figure 1.1. The outputs were adequate and were likely to contribute to the achievement of the results, though the timeframe was shorter for the achievement of the same, given the volatile and unstable context of implementation. Adjustments were made to refocus the causal links (arrows ⇧) across the results chain from the original ToC. The interlinking arrows (⇔) entailed linking the result areas to reflect integration within the programme and the contribution that implementation of the interventions and achievement of the results at both output and outcome levels results into the strategic goal. In addition, the evaluators added the modes of engagement and strategies for each thematic area. The assumptions and risks in the ToC fit well with the assumptions in the evaluation

helped facilitate knowledge-sharing and ensure the use of the evaluation results. Further, there were online engagement between the CO, ERG and the consultants in validating the deliverables and the results of the evaluation.

Mixed methods approach: The evaluation primarily used qualitative methods for data collection, including document review, interviews, and focus group discussions. The qualitative data were complemented with quantitative data to minimize bias. Quantitative data compiled through desk review of programme documents including reports, websites and online databases, to obtain relevant data on key CP indicators as stated in the results framework that measure change at output and outcome levels. The financial data were also accessed for analysis to determine the levels of performance by expenditure vis-à-vis the budget. The use of mixed methods in generating data for the evaluation is in line with the design, and enabled use of multiple sources of data to triangulate information before making conclusion on the gathered opinion.

1.3.1.3 Methods for Data Collection

The Evaluation Matrix (**Annex 5**) adapted to the country programme implementation context provided the framework of the evaluation and was key for the data collection and analysis. The Evaluation Matrix details what was evaluated, taking into consideration the evaluation criteria, evaluation questions and related assumptions assessed, defining the indicators. It also shows how the evaluation was done, eliciting the sources of information and data collection methods required to answer the evaluation questions. After data collection, the Evaluation Matrix provided the foundation for drafting the findings for each evaluation question and for drawing conclusions and formulating recommendations that cut across different EQs.

As mentioned earlier, the evaluation methods used both quantitative and qualitative methods for data collection. The **data collection methods** were designed around the evaluation questions, related assumptions and indicators proposed in the Evaluation Matrix and taking into account the limitations that that may arise during data collection. To ensure an effective and feasible way to collect the data and information required to fully answer the evaluation questions presented in this report, the evaluation team used data collection techniques as described in the section that follow. Key to note is that in compliance with the UNEG Ethical Guidelines for Evaluation, the evaluation team clarified the purpose of the CPE to the respondents and verbally sought their consent before beginning any interview sessions, especially during interviews and FGDs.

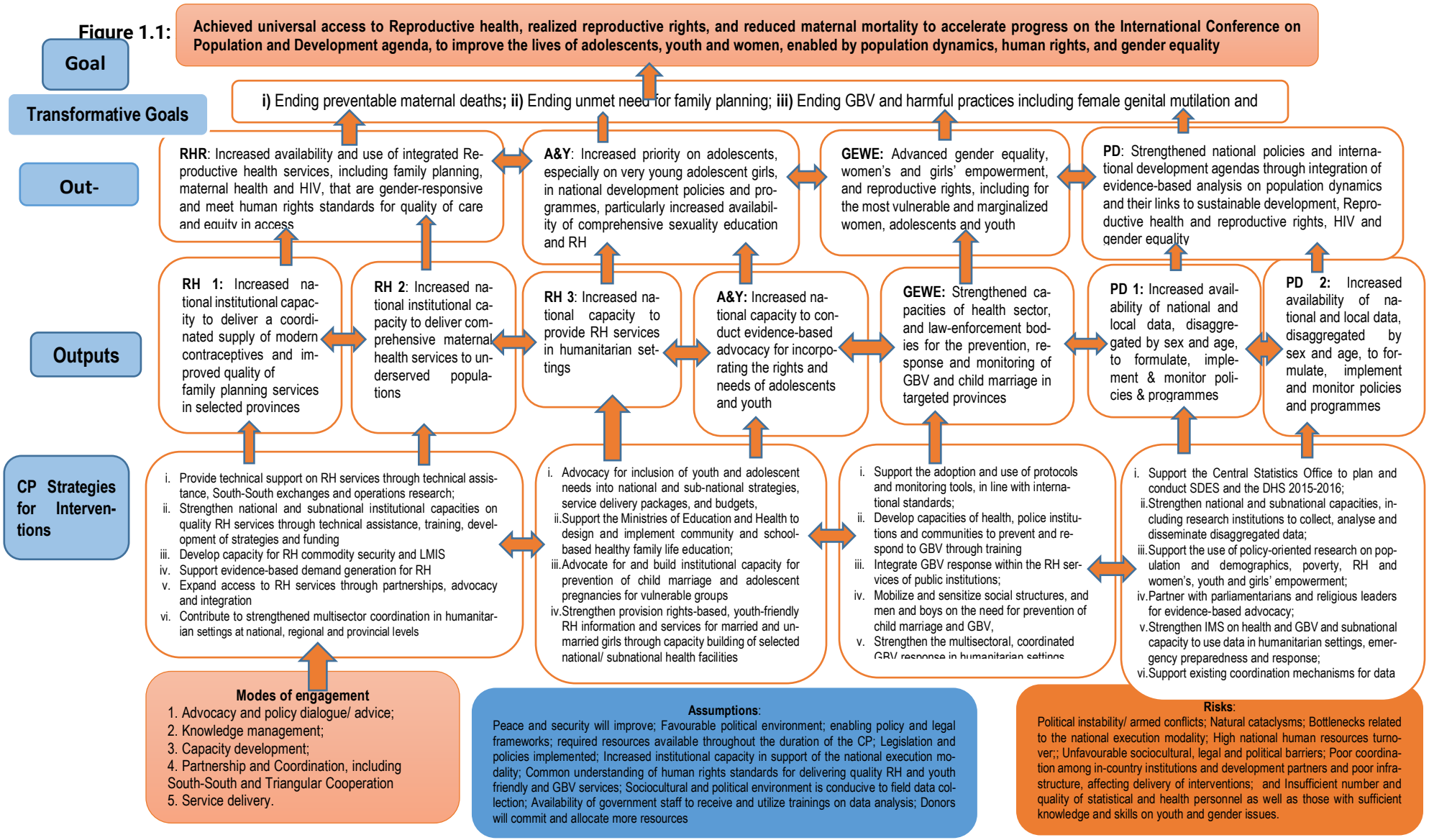
Document Review: This entailed, but not limited to review of programme-related documents and analysis of their content to elicit the CP design, implementation and management, and monitoring and evaluation. The consultants conducted the initial review of programme documents to inform the design report of the CPE. This was a continuous process during the evaluation, to enrich the quality and content of the report. Over the course of the evaluation, the evaluation team identified and obtained other key documents with the support of the UNFPA Afghanistan CO, in addition to other related secondary sources to inform the evaluation process.

Documentary evidence was a major part of this evaluation given the constraints that arose in accessing primary data, especially in the context of COVID-19, security and travel restrictions, where some information were not accessed from the primary sources. Further, the quantitative performance of the programme as defined by the CPD Results Framework informed by documentary evidence in the various reports provided by the UNFPA Afghanistan CO [List of documents reviewed are in Annex 3]. These have been referenced as appropriate in the report, to provide evidence-based feedback on the programme performance.

Key Informant Interviews (KII): This entailed conducting interviews with individuals or groups as key informants from a range of stakeholders identified in the stakeholders' map (Annex 7). This technique was useful in getting feedback and inputs from the processes and results of the Country Programme for those who interacted with the programme both at field and policy levels based on the objectives of the CPE. The respondents included key stakeholders of the Country programme, including donors and strategic partners[8].

[8]The Strategic partners are those implementing similar programmes as UNFPA and will be contacted for their relevance in the framework of implementation

Figure 1.1:


Goal
Achieved universal access to Reproductive health, realized reproductive rights, and reduced maternal mortality to accelerate progress on the International Conference on Population and Development agenda, to improve the lives of adolescents, youth and women, enabled by population dynamics, human rights, and gender equality
Transformative Goals
i) Ending preventable maternal deaths; ii) Ending unmet need for family planning; iii) Ending GBV and harmful practices including female genital mutilation and
Out-
RHR: Increased availability and use of integrated 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
A&Y: Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and RH
GEWE: Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth
PD: Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, Reproductive health and reproductive rights, HIV and gender equality
Outputs
RH 1: Increased national institutional capacity to deliver a coordinated supply of modern contraceptives and improved quality of family planning services in selected provinces
RH 2: Increased national institutional capacity to deliver comprehensive maternal health services to underserved populations
RH 3: Increased national capacity to provide RH services in humanitarian settings
A&Y: Increased national capacity to conduct evidence-based advocacy for incorporating the rights and needs of adolescents and youth
GEWE: Strengthened capacities of health sector, and law-enforcement bodies for the prevention, response and monitoring of GBV and child marriage in targeted provinces
PD 1: Increased availability of national and local data, disaggregated by sex and age, to formulate, implement & monitor policies & programmes
PD 2: Increased availability of national and local data, disaggregated by sex and age, to formulate, implement and monitor policies and programmes
CP Strategies for Interventions
i. Provide technical support on RH services through technical assistance, South-South exchanges and operations research;
ii. Strengthen national and subnational institutional capacities on quality RH services through technical assistance, training, development of strategies and funding
iii. Develop capacity for RH commodity security and LMIS
iv. Support evidence-based demand generation for RH
v. Expand access to RH services through partnerships, advocacy and integration
vi. Contribute to strengthened multisector coordination in humanitarian settings at national, regional and provincial levels
i. Advocacy for inclusion of youth and adolescent needs into national and sub-national strategies, service delivery packages, and budgets,
ii. Support the Ministries of Education and Health to design and implement community and school-based healthy family life education;
iii. Advocate for and build institutional capacity for prevention of child marriage and adolescent pregnancies for vulnerable groups
iv. Strengthen provision rights-based, youth-friendly RH information and services for married and unmarried girls through capacity building of selected national/ subnational health facilities
i. Support the adoption and use of protocols and monitoring tools, in line with international standards;
ii. Develop capacities of health, police institutions and communities to prevent and respond to GBV through training
iii. Integrate GBV response within the RH services of public institutions;
iv. Mobilize and sensitize social structures, and men and boys on the need for prevention of child marriage and GBV,
v. Strengthen the multisectoral, coordinated GBV response in humanitarian settings
i. Support the Central Statistics Office to plan and conduct SDES and the DHS 2015-2016;
ii. Strengthen national and subnational capacities, including research institutions to collect, analyse and disseminate disaggregated data;
iii. Support the use of policy-oriented research on population and demographics, poverty, RH and women's, youth and girls' empowerment;
iv. Partner with parliamentarians and religious leaders for evidence-based advocacy;
v. Strengthen IMS on health and GBV and subnational capacity to use data in humanitarian settings, emergency preparedness and response;
vi. Support existing coordination mechanisms for data
Modes of engagement
1. Advocacy and policy dialogue/ advice;
2. Knowledge management;
3. Capacity development;
4. Partnership and Coordination, including South-South and Triangular Cooperation
5. Service delivery.
Assumptions:
Peace and security will improve; Favourable political environment; enabling policy and legal frameworks; required resources available throughout the duration of the CP; Legislation and policies implemented; Increased institutional capacity in support of the national execution modality; Common understanding of human rights standards for delivering quality RH and youth friendly and GBV services; Sociocultural and political environment is conducive to field data collection; Availability of government staff to receive and utilize trainings on data analysis; Donors will commit and allocate more resources
Risks:
Political instability/ armed conflicts; Natural cataclysms; Bottlenecks related to the national execution modality; High national human resources turnover;; Unfavourable sociocultural, legal and political barriers; Poor coordination among in-country institutions and development partners and poor infrastructure, affecting delivery of interventions; and Insufficient number and quality of statistical and health personnel as well as those with sufficient knowledge and skills on youth and gender issues.

Those targeted included UNFPA Afghanistan CO staff, officials from the government line ministries, representatives of UN agencies, UNFPA donors, strategic partners, and national and international NGOs as implementing partners, among others. Group interviews[9] were conducted with key informants to collect key information on progress towards the intended outputs and outcomes of the Country Programme. The evaluation team used interview guides for KIIs with stakeholders (UNFPA staff, government counterparts, donors, other UN agencies, and national and international implementing partners) in the various thematic areas of programming. The interview guides were designed and captured gender and other disaggregated information and providing insights into the various needs across the gender and sex divide, and others marginalized groups like IDP, PWDs, among others. The respondents were also a mix of male and female.

Focus group discussion (FGD) – The FGDs have been designed to gather information among primary programme beneficiaries, including those benefiting from UNFPA capacity building interventions in the period of coverage. These were targeted to include government staff like the health workers, statistics and planning department, among other ministry staff who directly benefited from the UNFPA CP support, midwifery trainees, adolescent and youth, and community level beneficiaries like women and girls supported by UNFPA CP. The discussion guides were designed thematically to gather information regarding the extent to which the programme achieved its intended results, in addition to establishing some of the arising needs and/or unintended results. This technique was used based on its advantage of collecting data quickly and effectively from a large number of programme beneficiaries. Its preference was also on ability to provide further insights into data obtained from other categories of respondents. In order to enrich the data on the performance of the programme, the evaluators used purposive sampling selecting participants in the FGDs, especially beneficiaries, guided by their interaction with the programme, in addition to ensuring that specific performance issues are captured as guided by the evaluation questions. This was to ensure balanced representation of respondents from all the different socio-economic backgrounds. While each FGD aimed to compose of at least 8-10 participants ensuring balance in terms of sex and programmatic focus area, the evaluation team was cognizant of the limitations posed by COVID-19 control-restrictions on gathering and the possible remote nature of data collection to reduce the number of participants. Further, the evaluation team was composed of local consultants who were able to access the beneficiaries in their areas of residence, especially for sessions with beneficiaries, all of whom were able to better express themselves in the local language, movement allowing, to conduct the discussions. Among the consultants was also a lady who facilitated sessions with women and girls on sensitive topics, especially on sexuality and GBV, considering the conservative nature of the context on discussions on sexuality. The FGD guides were also engendered to capture gender related details to inform the programme's performance along gender lines, in addition to collecting other disaggregated details of beneficiaries; for example, the CPE team sought to know the male involvement in FP services and how they were influencing the uptake of the services.

Site Visits and photography: Based on the results of the document review and consultations with the UNFPA Afghanistan CO, and situation allowing, the evaluation team conducted site visits in the course of data collection in order to enrich the evidence base for this CPE. This was done through observing operations in real circumstances and/or to meet programmes' activities' participants to talk about UNFPA activities in Afghanistan and results achieved up to the time of the CPE. Given the travel restrictions due to COVID-19, and insecurity, the evaluation team only conducted visits to sites within Kabul, and conducted teleconferences with beneficiaries in various provinces outside Kabul, where the programme activities were implemented.

Field organization

Organization of field data collection were dependent on proper planning between UNFPA and the evaluation team. The Evaluation team worked with the Planning, Monitoring and Evaluation Officer to mobilized and secure appointments with the list of respondents as selected and shared by the evaluation team. The UNFPA evaluation focal

[9] Groups interviews were conducted in situations where various contributions from members of an office or entity were collected during an interview session, for example sessions with the CO thematic members can include more than one person during the interviews.

point(s) together with the respondents, determined the mode of interview, whether it was by face-to-face, Zoom, WhatsApp or telephone. The evaluation team ensured that all the respondents and participants observed social distancing, including having face masks and accessible to a sanitizer during the interview sessions to minimize exposure to COVID-19 risk.

1.3.1.4 Data Validation, Analysis and Report Writing

The evaluation team validated collected data on a routine basis through debriefing sessions, building themes along the CPE objectives. The data analysis methods employed depended on the type of data gathered to contribute to the findings of the report. The quantitative and qualitative data from primary and secondary sources were assessed and referenced, with findings and systematically triangulated to ensure that they were robust. The process involved contribution analysis, content analysis and trend analysis. Beneficiary focus group and key informant interviews were assessed through thematic content analysis, and data were quantified, where appropriate, from different primary sources. Contribution analysis identified how far documented inputs and activities were sufficient and relevant to the outputs and outcomes and likely to have contributed meaningfully to them. This involved exploring the theory of change in the results chain logic for each component area of the country programme. In addition, descriptive statistics have been used to describe or summarize key characteristics of quantitative data obtained from secondary sources, especially, the programme COAR and financial reports. The descriptive statistics have been presented in the form of charts and graphs for financial reports. The evaluation matrix has informed the analysis and report writing.

1.3.2 Selection of the Sample of Stakeholders

The evaluators adopted a participatory approach in selecting the stakeholders to participate in the evaluation as respondents. Based on the initial stakeholders' map provided by the UNFPA Afghanistan CO and a review of Atlas project and relevant programme documents provided by the CO in preparation for this design report, and the initial discussion with the UNFPA thematic component teams, the evaluators selected stakeholders to participate in the CPE. The stakeholders map identified the stakeholders involved in the design, implementation and monitoring of the 4th Country Programme (2015-2021), and those partners who did not work directly with UNFPA, yet played a key role in a relevant thematic area of programming or specific outcome area of the Country Programme. The stakeholders' map constituted the sampling frame for KIIs, group discussions and FGDs. Further, in consultation with the UNFPA Afghanistan CO staff, as well as complementary document reviews, the final list of stakeholders to participate in the KIIs, FGDs and group interviews were identified.

The evaluation focused on major categories of stakeholders across the thematic areas of programming or outcomes areas of the 4th Country Programme. As per the scope of the CPE, the consultants identified respondents from all the geographical areas (provinces and districts) the programme covered. This also determined the selection of the respondents, especially based on geographical coverage in the country. While the programme was implemented in nearly all the provinces, the IPs selected were representative of the programme areas covered and due to their length of engagement by UNFPA, where the evaluators selected those with longer stint with UNFPA to be able to talk about the achievements of the CPs, and have been selected to participate in the CPE activity. Specific interventions in various locations, like youth activities or safe GBV houses were selected in consultation with the team on the ground. Further, the consultants also ensured as much as possible inclusion of various beneficiary groups e.g. those from marginalized groups, including people living with disability (PWD), women, girls and boys. The following were the respondents selected and participated in the CPE:

- **UNFPA Afghanistan CO staff:** Senior management of the UNFPA Afghanistan CO; technical specialists and associates in the thematic areas of programming of the CP; and staff of operations and cross-cutting units, in the main office in Kabul and the field offices. They were selected based on their hands-on experience on the performance of the CP.
- **Government counterparts:** Officials of relevant line ministries and institutions (Public Health, Economics, Interior, Education, Higher Education, Women Affairs, Deputy Ministry of Youth Affairs, Justice, Hajj and Religious Affairs and National Statistic and Information Authorities (NSIA), National Parliament, Ministry of Inte-

rior, among others) and other government institutions in the supported provinces, as appropriate.

- **Implementing partners:** Staff of non-governmental organizations in their respective areas of coverage (Ref. Annex 7).
- **Direct beneficiaries:** These included the direct beneficiaries, be it through capacity building and development or service delivery support, including health workers, adolescents and youth, health facility staff, economics and statistics department trainees, education staff, midwives and trainees, among others.
- **Indirect beneficiaries**: Women of reproductive age, adolescents and youth in communities at programme implementation sites of UNFPA and its implementing partners, including clients of reproductive and maternal health, as well as family planning services; adolescents and youth participating in youth-led programmes and various activities and capacity building workshops at youth centres; religious leaders, among other indirect beneficiaries.
- **Donors:** Representatives of bilateral donor agencies funding interventions implemented by UNFPA and/or implementing projects in thematic areas of programming of UNFPA and geographic areas where UNFPA and its IPs operate.
- **United Nations agencies**: The United Nations Resident Coordinator and the United Nations Emergency Relief Coordinator, and representatives of relevant United Nations agencies (UNDP, UNICEF, WHO, UN Women were identified with the UNFPA team; including members of system-wide development and humanitarian coordination mechanisms (GBV sub-cluster and RH working group), where possible.
- **Special group** (Sub-cluster leads) – These were selected to gather information on the coordination mechanisms within the SC under UNFPA's leadership.

Table 1.2: Summary of the Sample

Type of Respondent	Type of Data Method	No. conducted
IPs	Group Interviews	10
Government	Group/Individual Interviews	9
UN Agencies	Group/Individual Interviews	6
UNFPA	Group/Individual Interviews	9
SC Co-Leads	Group/Individual Interviews	3
Beneficiaries	FGDs	11

As stated earlier, purposive sampling technique was used to select key informants for KIIs and group interviews from the final stakeholders' map. Selection of stakeholders for KIIs and group interviews were made premised on the following selection criteria:

- All types of main stakeholders for each output/outcome of the Country Programme - i.e., UNFPA CO staff, Government counterparts, IPs, direct and indirect beneficiaries, donors and other UN agencies.
- For each output/outcome, stakeholders associated to on-going activities as well as with activities (AWPs) that have already been completed.
- Stakeholders operating and/or located in the various geographic areas of the country where UNFPA and its implementing partners provide support.
- Stakeholders associated with financially large and financially modest AWPs.
- Stakeholders involved in activities with both national execution modality and direct execution modality.

Limitations, Risk and Biases

1. **Remote data collection mechanisms** due to the constraints emanating from the COVID-19 response and insecurity restrictions the consultants visited field locations only in Kabul and met the programme participants face-to-face, in addition to verifying some of the support provided by the CP, but not in the field outside Kabul. The evaluation team maximized liaison with the national consultants on the ground to visit some of the CP locations and were able to share with the team what they verified, like the Youth friendly centres, Malalai Fistula hospital, among others that were possible. The evaluation team utilized a lot of information from various reliable sources for triangulation of information shared by the respondents, and confident that the information shared in this report is reliable and can be verified.

2. Limited information and quality of relevant documents and reports given to the evaluation team. The evaluation team used cross validation from stakeholders, staff, secondary documents, in addition to using expert opinions for objective evidence, to mitigate the potential bias. On the other hand, none of the limitations was sufficient to invalidate the evaluation, and the team is confident that a wide, sufficiently representative range of stakeholders was reached at national and community levels.
3. Weak implementation of the M&E results framework posed inherent gaps in making conclusions on the performance of the CP in various result areas in the framework, especially on a number of achievements at the results levels. However, the evaluation team used triangulation, to qualitatively describe the extent of achievement through a number of data sources.
4. This CPE was based primarily on qualitative information collected from government counterparts and implementing partners (direct beneficiaries) rather than from programme indirect beneficiaries for evaluation of outcome level results, due to the nature of the design of the CP interventions, which were aimed at strengthening the capacity of the government and its stakeholders to deliver in key areas. The evaluation assessed achievement of the CP outputs and the likelihood of results at the outcome level. The scope of this exercise did not allow the team to collect quantitative data from the field, thus the analysis and conclusions are based on quantitative data collected from the Country Office through secondary sources. This is already a source of bias. However, the evaluation team triangulated the data sources to make conclusions on arising phenomenon, mitigating any bias that would have arisen based on data sources.
5. Inadequate details on disaggregated programme data and the extent to which the programme impacted the various targeted groups, limiting the consultants' level of analysis of the data. The consultants however designed CPE questions to capture information on various beneficiaries and how the programme impacted them, in addition to depending on related secondary data to conclude on the findings.

1.3.3 Evaluation Process

The overall evaluation process involved five phases: (i) preparation; (ii) design; (iii) field; (iv) analysis and reporting; and (v) facilitation of use and dissemination phase, as summarised in the table below.

Table 1.3: Evaluation Process and related activities

Phase	Main Activity
Preparatory (done by the CO)	Drafting and approval of the ToR and Hiring of Consultants; Establishment and orientation of the Evaluation Reference Group (ERG) Inform key stakeholders about the evaluation; Compile Initial list of documentation\Stakeholder mapping and list of Atlas Projects.
Design (Done majorly by the Evaluation Team)	Documentary review; Stakeholder mapping; Analysis and Reconstructing the intervention logic (theory of change) of the programme Finalization of the list of evaluation questions; and preparation of Evaluation Matrix; Developing data collection, sampling, and analysis strategy; Specifying limitations and risks in conducting the evaluation and plan mitigation strategies to overcome these limitations and risks; Drafting of the Design Report; Submission and approval of the Design Report
Field (Evaluation Team, with support from the CO)	Evaluation team conduct Data collection within COVID-19 constraints; Preliminary data analysis Debriefing meeting on preliminary findings, conclusions and recommendations to UNFPA CO, IPs and ERG
Reporting **(Evaluation Team, with support from the CO)**	Comprehensive data analysis, integrating comments provided during the debriefing with UNFPA CO and ERG; Development and submission of first draft of the CPE Report for review by the UNFPA CO and ERG; Preparation of Second Draft CPE Report based on review comments of UNFPA CO and the ERG; Submission of the Second Draft CPE Report for review; Evaluation Quality Assurance; Validation Workshop; Production of Final CPE Report; Approval of the CPE Report
Dissemination and Use (UNFPA)	Management response to the CPE recommendations Development of the dissemination strategy Dissemination of the CPE Findings and lessons learnt

CHAPTER 2: COUNTRY CONTEXT

2.1 Development Challenges

Afghanistan is a country with an area of 652,230 square kilometres located in the South Asia bordering with Pakistan in east and south west, Iran in west, Tajikistan, Uzbekistan and Turkmenistan in north with small attachment of border with China in north eastern part of the country. Afghanistan is still passing through four decades of instability, civil war and insurgency from the past forty years which destroyed country s' infrastructure, economy, human capitals and more. According to United Nations Development Programme (UNDP) Human Development Index Report, Afghanistan's human development index (HDI) value for 2018 is 0.496, which put the country in the low human development category, positioning it at 170 out of 189 countries and territories[10].

Since 2005, successive governments have faced multitudes of political, security, and economic issues. Current Government of the Islamic Republic of Afghanistan (GoIRA), which came into power recently, is committed to addressing key national issues, including institutional reform and development, programmatic and financial sustainability. The Government has devised a new macroeconomic framework, the Afghanistan National Peace and Development Framework (ANPDF), which is also facing implementation challenges, like inadequate human and financial resources.

The humanitarian situation in Afghanistan remains ominous, and exposes Afghanistan's development prospects to further risks. Political instability, natural disasters, influx of refugees and internal displacement make the country prone to humanitarian crises. Multiple, predictable and recurrent natural hazards are exacerbated by ongoing climate change.[11] Widespread natural disasters occur every year, affecting on average a quarter of a million people, most commonly floods, drought, earthquakes, extreme winter conditions and avalanches, affecting effects on the livelihoods and food supplies for a great number of the country's population. More than half a million people are internally displaced due to ongoing war and recurrent droughts and floods.

The *Gross Domestic Product* (*GDP*) in *Afghanistan* was worth 19.10 billion US dollars in *2019*, with a growth rate of 2.9 percent in *2019* according to official *data* from the World Bank and projections[12]. The proportion of population living below the national poverty line increased from 34 percent in 2007- 08 to 55 percent in 2016-17[13]. The the poverty gap ratio – more than doubled between 2007-08 and 2016-17, increasing from 7 to 15 percent[14]. The latest poverty figures imply that at the time of the survey, close to 16 million Afghans lived in poverty[15]. The education and literacy have a favourable effect on household welfare. While unemployment of the head of household is correlated with higher poverty, his/her employment is no guarantee against poverty, with more than half of the households with a fully-employed household head live below the poverty line[16]. The loss of wealth among the most affluent 20 percent of the population has been more pronounced than that at the bottom of the wealth distribution. This implies that, although poverty has increased, inequality in the country has declined. The Gini index for Afghanistan showed a small decrease between the surveys of 2011-12 and 2016- 17, from 0.30 to 0.29.[17]According to Afghanistan Living Conditions Survey (ALCS) 2016-17, job opportunities for young people are particularly scarce, with the youth unemployment rate standing as high as 31 percent. The overall labour force participation rate is relatively low at 54 percent, while the national employment-to population ratio of 41 percent. Agriculture constitutes 44 percent of the labour market of Afghanistan, while manufacturing employs 18 percent[18].

2.1.1 Reproductive health

Despite development challenges in multiple sectors, GoIRA has made significant progress in improving life expectancy and reducing mortality since 2000. Life expectancy rate at birth increased from 45 years in 2000 to 61 years in 2012.[19] These improvements were largely achieved through implementing a Basic Package of Health

[10] Human Development Index report 2019, UNDP
[11] Afghanistan National Peace and Development Framework
[12] World bank Data https://data.worldbank.org/indicator/NY.GDP.MKTP.CD?locations=AF
[13] Afghanistan Living Conditions Survey 2016 - 2017
[14] Ibid
[15] Ibid
[16] Ibid
[17] Afghanistan Living Conditions Survey 2016 - 2017
[18] Ibid
[19] Ending Preventable Maternal Mortality Profile Afghanistan 2019

Services (BPHS) and an Essential Package of Hospital Services (EPHS) in the country. By 2017, all secondary and tertiary health facilities had midwives and 90% of primary facilities; 66% of the population lived within one hour's travelling time to a health facility; 88% of the population lived within two hours' travelling time, and health posts with male and female community health workers had been established in more than 15,000 communities. [20]

Antenatal care and skilled birth-attended deliveries have increased in the last seventeen years from four percent to 65.2 percent and eight percent to 58.8 percent, respectively[21]. The contraceptive prevalence rate (CPR) has also increased nationally from 10% in 2006 to currently stand at 18.9 percent[22]. Further, a modern contraceptive prevalence rate of 17.4% indicates that the majority of these methods can be considered as 'modern', while nearly third of the women (32.0%) do not use any contraceptive methods[23]. The CPR among women from the lowest wealth quintile however dropped since a high of 14.2 percent in 2010/11 and is currently only 8.8 percent. Despite the registered improvements, fertility and maternal mortality remain high when compared globally and in the region. Afghanistan Demographic and Health Survey (DHS) reported total fertility rate (TFR) 5.3 in 2015, and the 2018 Afghanistan Health Survey reported this as 5.1. On the other hand, maternal mortality ratio decreased from 1,291 per 100,000 live births in 2015 to 638 in 2017[24], which is still among the highest in the world, with significant disparities within and between provinces. In addition, Afghanistan has enormous need for more maternal health services, especially in remote and hard to reach areas to improve access and public awareness on maternal care before, during and after pregnancy, and for family planning[25].

Afghanistan is committed to reducing Preventable Maternal Mortality and associated disparities, and this is evidenced in its National Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Strategy 2017-2021. These strategies articulate the Ministry of Public Health's (MoPH) vision for improving Reproductive, Maternal, Newborn, Child and Adolescent Health, and contribute to achievement of the Ministry of Public Health's overall National Health Strategy 2016–2020. The RMNCAH aims at reducing the unmet need for family planning, increasing utilization of quality skilled birth attendance, access to comprehensive obstetric care, essential and emergency care of sick newborns, national vaccination coverage, coverage of interventions for the prevention and management of child pneumonia and diarrhoea, and the treatment of severe acute malnutrition. UNFPA is investing in provision of integrated SRH services and GBV in Afghanistan.

2.1.2 Adolescent and Youth

Afghanistan has one of the world's youngest populations, with more than 63 per cent below the age of 25 and 46 per cent below the age of 15[26]. Only 62 per cent of young men and 32 per cent of young women aged 15 to 24 were reported to be literate in 2012. With approximately 53 per cent of all women aged 25 to 49 married by the age of 18, and 21 per cent married by the age of 15.

Early marriage and teenage pregnancies associated with increased chance of maternal mortality, illness and disability, including obstetric fistula and other pregnancy related complications are the major health challenges faced by youth and adolescents in Afghanistan[27]. According to the Ministry of Public Health's Afghanistan Mortality Survey in 2010, 21.3 percent of all women in the 25–49 age group were married by age of 15, and 53.2 percent were married by 18.11 by the age of 19, a third of women have started childbearing and 10 percent of women aged 15–19 have already given birth.

The risk of dying from pregnancy-related causes is significantly higher for young mothers than for older women. Afghanistan's pregnancy-related mortality ratio for girls aged 15–19 years is estimated at 531 compared to 257 for young women between the ages of 20 and 24 years (AMS 2010). Adolescents are at risk of early and unwanted pregnancy, of sexually transmitted infections (STIs) including HIV and AIDS, and vulnerable to the dangers of tobacco use, alcohol and other drugs. Many are exposed to violence and fear on a

[20] Afghanistan health surveys 2018
[21] Ibid
[22] Ibid
[23] Ibid
[24] Trends in Maternal Mortality 2000 – 2017: Estimates by WHO, UNICEF, UNFPA and World Bank Group
[25] UNFPA Afghanistan Annual Report 2017
[26] Country program document, UNFPA 2015-2019
[27] Afghanistan National Youth Strategy 2017-2021

daily basis[28]. During the period of review, UNFPA, for the first time in Afghanistan supported the government, through the Deputy Ministry of Youth Affairs to develop National Youth Policy together with a 5-year National Youth Strategy, with the hope that the policy would guide the youth programmes and the strategy[29].

2.1.3 Gender Equality and Women's Empowerment

Afghanistan being a state of conservative minded people where behaviours are cultivated on the values taken from local cultures or misinterpretations from religious principles, gender equality and women's empowerment are still considered new businesses. Women being half of the population have difficulties to access to their basic rights like education, health, access to media and information, participation in politics and decision making etc. In rural areas girls have less opportunity as compared to urban girls to go schools and access to media and information, face forced and teenage marriages and have poor access and decision making power to seek health care. According to ALCS 2016- 17, women in managerial positions was measured at 4 percent, indicating very low women's power in decision making in the economy[30].

The Afghanistan Gender Inequality Index (GII) 0.655, ranking it 157 out of 162 countries in the 2020 Human Development Report[31]. Further the report states that 27.4 percent of Afghanistan parliamentary seats are held by women, and 13.2 percent of adult women have reached at least a secondary level of education compared to 36.9 percent of their male counterparts. Female participation in the labour market is 48.7 percent compared to 82.1 for men. Gender inequality and women s' deprivation to understand and get their basic needs and rights remains a constant challenge of Afghan community. Lack of educational opportunities is the biggest problem facing women, followed by lack of rights, employment opportunities, violence, lack of services, and economic concerns[32].

Youth literacy rate is reported 68.2 percent for male and 38.7 percent for female. Similarly, adult literacy rate for female (19.9 percent) is calculated lower than male (49.4 percent). Number of women participating in labour force is around one third of men (2.1 million women vs 6.4 million men). The share of youth (age 15-24 years) not in education, employment or training (NEET) is 16.6 percent male compared to 67.9 percent of female. Unemployment rate for female is reported 47.4 percent by ALCS as compared to the 24.5 percent of male. [33]More than half (53%) of the ever-married women age 15-49 have experienced physical violence at least once since age 15, and 56% of ever-married women age 15-49 report ever having experienced emotional, physical, or sexual violence from their spouse. Among ever-married women who had experienced spousal physical violence in the past 12 months, 26% reported experiencing physical injuries. Sixty-one percent of ever married women who experienced violence never sought help or never told anyone about the violence. Efforts to reform family and divorce law have not succeeded. Discrimination and a critical shortage of lawyers mean that women are frequently unable to claim property and inheritances. Most female prisoners in Afghanistan have been jailed for so-called "moral crimes", which can involve nothing more than running away from an abusive husband. Despite the gaps mentioned, there have been evidences that reported progress toward improvement in gender equality and women empowerment.

Since the fall of the Taliban regime, women s' participation in economy has improved. According to the Afghanistan Women's Chamber of Commerce and Industries, investments by women now reach more than USD 77 million and provide jobs for 77,000 individuals nationwide. Women make up 27% of the national parliament and are politically active at lower levels as well. Lower house elections in 2018 saw a record of 417 women[34] running for office. More than ever, women are also present in prominent positions, including on provincial councils, ministries and the High Peace Council, but their overall political representation still lags behind that of men. Women account for only 22% of civil service

[28] Afghanistan National Youth Strategy 2017-2021
[29] https://afghanistan.unfpa.org/en/news/deputy-ministry-youth-affairs-supports-draft-national-youth-policy-presented-afghan-young
[30] Afghanistan living conditions survey 2016-17
[31] UNDP HDI report 2020 http://report.hdr.undp.org/
[32] Survey of the Afghan people 2019
[33] Afghanistan demographic health survey 2015
[34] Afghanistan, https://www.af.undp.org/ content/afghanistan/en/home/country-info.html

staff, 7% of senior government positions and 1.4% of the security services.

2.1.4 Population Dynamics

It is challenging to make a precise description of the population dynamics in Afghanistan due to the fact that no population census has been conducted since 1979, and population indicators are calculated based on estimation. The Afghanistan population is currently estimated by Central Statistical Office and other sources at 32,890,171[35] (2020-21), with a population growth rate of 2.33 percent per year. Life expectancy rate at birth is calculated 64.2 years for female and 63.6 years for male[36]. Afghanistan is a mountainous country where 72-75% of the population is living in rural areas. In 2019, 24.4 [37]percent of the population lived in urban settlements, 71 percent in rural areas, and 4.6 percent were nomadic. The urban population is mainly found mainly in the 5 big cities (regional capitals) namely Kabul, Kandahar, Hirat, Mazari-Sharif and Jalal Abad. Unemployment rate for 2019 is estimated 11.1 percent with a small increase from the previous year[38]. A projection of population in the next 10 years, modelling a decrease of fertility rate to 3.01 and a constant rate, by 2030, the is estimated at 49,396,168 and 54,424,092 respectively[39].

Due to the political instability and conflict in the country a significant slice of Afghan population is still living in Pakistan and Iran. Some of these refugees return to their home country each year because of host country pressure or any other reason while some more people seek asylums to go outside the country. As reported by UNCHR in [40]November 2019, 1,412,476 Afghans live in Pakistan and 979,410 Afghans live in Iran as refugees. The report adds that by November 2019 7,985 registered refugees and 461, 239 undocumented (IOM) refugees returned to Afghanistan from all countries.

Beside refugees, internally displaced people are another concern for Afghan Government and international community to provide basic services and protection. It is estimated that more than 4.1 million people displaced since 2012 remain displaced from their villages,12 many into urban areas, and are showing no signs they intend to return home According to NRC's Internal Displacement Monitoring Centre (IDMC), the total internally displaced populations in Afghanistan stand at 4,191,000 (2,993,000 due to conflict and violence, while 1,198,000 due to natural disasters)[41]. Women of reproductive age and adolescent girls in IDP settlements affected by under-nutrition suffer adverse effects on their own health, as well as later on the birth outcome of their infants[42]. Further, amongst displaced households, some 32 per cent report unavailability of antenatal care where they live due to a combination of factors including a lack of health facilities within an accessible distance, an inadequate number of qualified health staff, and unavailability of female health workers. The situation is worse in provinces that have been affected by prolonged conflict and those which are hosting people with protracted needs[43]. Women and girls are also deprived of basic rights, particularly education, and gender based violence is pervasive. The internally displaced people add more expenses and work to the efforts of both Government and international community to settle and access to their basic needs and rights.

There is no reliable vital statistics system or population registration system, leading to very considerably variations in population estimates[44]. The Government of Afghanistan, through the Ministry of Economy, with support from UNFPA developed its first yet-to-be approved National Population Policy (NPP)[45], a guiding document to assess the impact of population dynamics, reproductive health and gender on poverty, the need to respond to new challenges pertaining to population and development and the changing development environment.

2.1.5 COVID-19 in Afghanistan

The COVID-19 outbreak was announced as public health emergency by WHO on Jan 30, 2020. On 24 February 2020 first COVID-19 positive case confirmed in Herat province of Afghanistan. The COVID-19 cases in the country stands at

[35] Estimated population of Afghanistan, NSIA, https://www.nsia.gov.af/
[36] Afghanistan Mortality Survey (AMS) 2010, https://dhsprogram.com/pubs/pdf/fr248/fr248.pdf
[37] Estimated population of Afghanistan, NSIA, https://www.nsia.gov.af/
[38] Afghanistan unemployment rate, https://www.macrotrends.net/countries/AFG/afghanistan/unemployment-rate
[39] UNFPA/NSIA, Afghanistan Population Projection and its Impact on Development (2017-2030)
[40] UNCHR Operational Update November 2019
[41] https://www.internal-displacement.org/countries/afghanistan
[42] Afghanistan Humanitarian Needs Overview 2020
[43] Ibid
[44] Population Dynamics in Afghanistan: Concept Note 2018
[45] UNFPA 2017

37,599, standing at position 57 worldwide, among the countries reporting cases[46]. Afghan government with support of international community started intervention in all provinces with special focus on public awareness, surveillance, infection prevention, and treatment of the infected people.

The Government of Afghanistan jointly with its partners started a multipronged approach to effectively respond to the COVID19 emergency. The COVID-19 emergency response focused mainly on strengthening leadership and coordination, risk communication and public awareness, surveillance and case detection, infection control and prevention, and isolation and management of the suspected and confirmed cases throughout the country.

Only one central public health laboratory in Afghanistan's capital, Kabul, is currently doing diagnostic tests for COVID-19, with a maximum capacity of 50 tests per day, costing US$1,600 per diagnostic kit[47]. The absence of local laboratories to do diagnostic tests for COVID-19 creates considerable delays in treating and isolating patients in hospitals in distant parts of the country. Because of inadequate health-care services in Afghanistan, many ill people will try to seek medical care oversees while wide travel restrictions and flight suspensions come into force in the country.

Based on the NSIA White Area Identification study, roughly around 10-20% of the country population do not have access to basic health services. In addition, transportation services are poorly established in the hard-to-reach areas. With a healthcare system already stretched to the limits, ongoing conflict and natural disasters, widespread food insecurity and reductions in foreign aid, stakeholders in Afghanistan were already facing a complex and worsening situation. COVID-19 has the potential to disastrously exacerbate this, which are likely to affect access to RHR and GBV services as those are the areas targeted by UNFPA. Further, the restrictions to movement due to COVID-19 affect access to various health services, including GBV and RH and GBV. All these concerns suggest that the far rural and hard-to-reach areas should be prioritized for the provision of health services including RH.

2.2 The Role of External Assistance

There has been massive flow of foreign aid to Afghanistan since the inception of the new Afghan government in 2001. Foreign aid in Afghanistan flows in from mainly in three ways, namely; directly to the government through the Afghanistan Reconstruction Trust Fund; Secondly, through those that are indirectly connected with the government such as local and international NGOs; and lastly through channels that function outside the governmental network such as the coalition forces and other international NGOs that bring in their own fund. This comes in mainly two forms in Afghanistan, military and non-military aid. While Afghanistan has achieved remarkable progress in increasing revenues over recent years, the gap between revenues and expenditures remains wide. Afghanistan continues to rely on grants to finance 75 percent of its total public expenditures. Total revenues currently amount to around $2.5 billion per year [48] while expenditures reach around $11 billion per year[49].

There is lack of clear and agreed upon available data of the international assistance to Afghanistan. One reason could be that the majority of aid fund is not channelled through government entities and instead spent by international organizations persuaded by different international donors. A study [50]report "Aid effectiveness in Afghanistan March 2018" pointed out that external development aid to Afghanistan reduced after 2011. In this report total aid amount by international community by year from 2010 to 2017 is reported as in the following table:

Table 2.1: ***Volume of committed aid vs disbursed aid from 2009/10 – 2016/17***

Year	Committed (USD Mil.)	Disbursed (USD Million)	Percentage Disbursed
2009/10	5,884	1,784	30.3
2010/11	16,791	10,900	64.9
2011/12	9,206	6,011	65.3
2012/13	6,259	3,889	62.1
2013/14	4,767	2,838	59.5

[46] https://www.worldometers.info/coronavirus/#countries, accessed on 18/08/20
[47] COVID-19: the current situation in Afghanistan, Lancet April 2020
[48] United Nations Development Assistance Framework for Afghanistan 2015 -2019
[49] https://www.nytimes.com/2019/12/05/world/asia/afghanistan-aid-world-bank.html
[50] Aid effectiveness in Afghanistan March 2018, SCA/Oxfam

2014/15	4,055	4,002	98.7
2015/16	4,363	3,734	85.6
2016/17	2,894	2,064	71.3
Total	**54,219**	**35,222**	**65.0**

Source: AGCSO

According to the report, from 2010 to 2015 United States of America with amount of US$11034 million was the greatest contributor to the development aid for Afghanistan. Also UK spent US$2044 million, EU US$1421 million, Sweden US$588 million, Norway US$596 million, Japan US$3047 million, Germany US$ 2492 million, Denmark US$395 million, Canada US$684 million and Australia spent US$910 million for the development of Afghanistan

Due to the current extent of dependence on aid, a sharp reduction in either security or civilian grants would mean insufficient resources to meet pressing expenditure needs, including: security spending, delivery of basic government functions such as social services and infrastructure, public investments for faster economic growth and poverty reduction, and short-term job creation and community development programmes following a political settlement, which will be vital to sustain and consolidate peace. The situation even further deteriorates if COVID-19 pandemic continue for the coming years.

CHAPTER 3: UNITED NATIONS / UNFPA RESPONSE AND PROGRAMME STRATEGIES

3.1 UNFPA Strategic Response

Globally, UNFPA supports reproductive health care for women and youth, to include the health of pregnant women, especially those who face life-threatening complications; promotion of birth spacing and reliable access to safe birth supplies; training of health workers to help ensure skilled attendants supervise childbirth; prevention of gender-based violence and harmful practices, including early and child marriage; delivery of dignity kits and other life-saving materials to survivors of conflict and natural disasters; and conducting censuses, data collection and analyses which are essential for development planning.

UNFPA contributes to the achievement of SDGs and the PoA of International Conference on Population and Development (ICPD) – held in Cairo in 1994 – to reduce infant and child mortality, reduce neonatal and maternal mortality and increase access to reproductive health services including family planning. The Cairo consensus placed population and development issues within a human rights-based framework, and UNFPA is committed to integrating human rights into its work globally.

The UNFPA Strategic Plan 2018-2021 is aligned with the 2030 Agenda for Sustainable Development. The goal is to "achieve universal access to Reproductive health, realize reproductive health rights, reduce maternal mortality and improve the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality".[51] This is also aims to accelerate progress on the International Conference on Population and Development (ICPD) agenda is directly aligned with Sustainable Development Goals (SDGs) 3 and 5 which are good health and well-being and gender equality. In addition, UNFPA is working in the areas of SDG 10 (reduced inequalities), 16 (peace, justice and strong institutions) and 17 (partnership for the goals), which are key enablers for the organizational goals.

One UN for Afghanistan details the actions to be taken to help Afghanistan achieve certain outcomes outlined in the ANPDF and its associated NPPs. The work of UN agencies in Afghanistan is clustered in four thematic areas which contribute to the various National Priority Programs (NPPs) within the ANPDF, i.e. education; food security, nutrition and livelihoods; health; return and reintegration; the rule of law and normative work including human rights advocacy and protection, and promoting international regulations and guidelines. UNFPA responds in four thematic areas of Reproductive Health, Adolescents and Youth, Gender Equity and women's empowerment, and Population Dynamics. The UN 'delivering as one' approach in Afghanistan captured in the ONE UN

[51] UNFPA Annual Report 2018

document (UNDAF) aims to ensure effective coordination by reducing duplication, cutting costs and promoting accountability.[52]

3.2 UNFPA Response through the Country Programme

UNFPA started working in Afghanistan in 1976. During the years of conflict in the country, UNFPA provided reproductive health services to the Afghan refugees in Pakistan and Iran. In 2002, after the fall of the Taliban, UNFPA re-established its country office in Afghanistan. The UNFPA long term support programme in Afghanistan was initiated with the rehabilitation of 3 maternal hospitals in Kabul. Since then, UNFPA has implemented three Country Programmes, providing financial and technical support to the Afghan Government.[53] In 2010, UNFPA launched its Third Country Programme (2010-2014). During this period, UNFPA promoted the utilization of information and services on reproductive health, fostered an environment in which gender-based violence can be eliminated and helped young people in adopting healthy lifestyles. UNFPA supported the collection and use of accurate socioeconomic data so that development decisions might be taken based on robust evidence.[54] UNFPA's mandate promotes the organization to work in the areas of Sexual Reproductive Health and Rights (RHR), Population Dynamics (PD) and Gender Equality and Women's Empowerment (GEWE). It is also mandated to work in humanitarian assistance and with youth networks and to fulfil a coordination role.[55]

3.2.1 Brief Description of UNFPA Previous Cycle Strategy, Goals and Achievements

The third UNFPA Afghanistan country programme, implemented from 2010 to 2013, with an extension to 2014, to in line with the extension of the United Nations Development Assistance Framework (UNDAF), 2010-2013, and developed to respond on national priorities in the Afghanistan National Development Strategy, including Millennium Development Goals sought to contribute to the achievement of three UNDAF priority areas of governance, peace and stability; sustainable livelihoods; and basic social services[56]. Implemented focusing on three components name reproductive health and rights; population and development; and gender equality, while mainstreaming RH and the prevention of HIV and sexually transmitted infections integrated throughout the two outcomes.

Among the various achievement of the 3rd CP, notable was the contribution to the overall regional reductions in maternal mortality and an increase of skilled birth attendance from 10 to 29 per cent, increased contraceptive prevalence, and increased number of health facilities with at least three contraceptive methods in four provinces. In addition, the CP contributed to the development and revision of numerous health and gender policies and strategies; improving access to basic obstetric care by expanding services to underserved areas in the four provinces of operation; increasing the use of family planning and reproductive health services; improving government capacity to collect, analyse and utilize population data and to undertake four provincial SDES; and strengthening the capacity of parliamentarians and religious leaders to advocate for policies addressing population and elimination of GBV. The development and implementation of the fourth country programme (2015 – 2019) was premised on the achievements and experiences, of the 3rd CP, including recommendations from its evaluation.

3.2.2 Current UNFPA Country Programme

The fourth Country Programme Document (CPD) of the Government of the Islamic Republic of Afghanistan (GoIRA) and the United Nations Population Fund (UNFPA), initially developed and approved for implementation in the period 2015-2019, but got approval for further extension to end in 2021 to harmonize with; a) UNDAF extension from initially 2015 – 2019, to 2020-2021, and the One UN for Afghanistan 2018-2021, b) the national planning cycles since the Afghanistan National Peace and Development Framework is until the end of 2021, c) UNFPA Strategic Plan 2018-2021, and d) the commitments made by the international community to Afghanistan

[52] UNFPA Annual Report 2018
[53] UNFPA Annual Report 2017
[54] UNFPA 4th CPD
[55] Evaluation of UNFPA's Country Program 3 (CP3) in Afghanistan 2010 – 2013
[56] DP/**FPA**/CPD/AFG/3

during the conference in 2016[57]. Developed, hinged on a human rights based lens, the programme sought to accelerate reduction of vulnerabilities and disparities, especially among people living in remote areas, working on issues of disabilities, youth and the most at risk population, reaching out to the most disadvantaged groups using culturally-sensitive approaches. The programme contributes to addressing the development and humanitarian challenges bedevilling Afghanistan.

The programme is mainly implemented through partnerships including government and non-governmental focusing on the national level delivery[58]. The UNFPA Strategic Plan 2014-17 guided the development of the country programme, but this was later aligned with the UNFPA Strategic Plan 2018-2021[59]. The Country Programme Action Plan (CPAP) operationalizes the commitments outlined in the CPD and contributes to the United Nations Development Assistance Framework (UNDAF) 2015-2021 and to the One UN Programme Document which was jointly developed by UN agencies in Afghanistan in close partnership with and full leadership of the Government of Afghanistan. The CPD outputs are designed and realigned to contribute to and complement the national priorities outlined in the Afghanistan National Peace and Development Framework (ANPDF), National Priority Programme (NPP), government sector policy and priorities and the Afghanistan Sustainable Development Goals (ASDGs).

The CP strategic outcomes and operational outputs, in Table 3.2 below shows the four outcomes of the programme. It has a total of seven outputs, with the RH component has three, Population dynamics component has two, while GEWE and Adolescents and Youth each has one. The programme is implemented using different strategies in the country aimed at increasing access and availability to RH services, GBV response and availability of data for evidence-based decisions. These are explicitly shown in the strategic outcomes and operational outputs.

Table 3.2: Country Programme Outcomes and Outputs

National priority: Improve the health and nutrition of the people of Afghanistan through quality health-care services provision and the promotion of a healthy lifestyle		
Strategic Plan Outcome	**CP Output**	**Interventions/ Strategies**
Outcome 1: Reproductive health: Increased availability and use of integrated 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	**Output 1:** Increased national institutional capacity to deliver a coordinated supply of modern contraceptives and improved quality of family planning services in selected provinces	• Provide technical support to develop rights-based policies and promote implementation of the national family planning programme; • Strengthen national and subnational institutional capacities for the provision of quality family planning counselling and a wider choice of contraceptives, including for young women, IDPs and persons with disabilities; • Develop capacity for reproductive health commodity security, including supply chain management and the logistics management information system; • Support evidence-based demand generation initiatives for family planning • Expand access to contraceptives services through public and private sector partnerships
	Output 2: Increased national institutional capacity to deliver comprehensive maternal health services to underserved populations	• Expand access to basic and comprehensive emergency obstetric care services by advocating for their integration into the health care system, promoting pooled funding of innovative models and training healthcare workers, • Strengthen specialist training for the treatment of obstetrics fistula, and increase the number of provinces where such services are available; • Provide support for in-service training of health care providers in integrated reproductive health services; • Strengthen capacities for quality midwifery education delivery and regulation, and promote the professional midwifery association; and

[57] The UNFPA Afghanistan 4th Country Programme Evaluation Terms of Reference and CPD

[58] Country programme document for DP/FPA/CPD/AFG/4

[59] Document review and Interviews

		• Conduct research to support evidence-based planning on maternal health.
	Output 3: Increased national capacity to provide Reproductive health services in humanitarian settings	• Strengthen the health care system to ensure its capacity to implement the minimum initial service package; • Contribute to strengthened multisectoral coordination in humanitarian settings at national, regional and provincial levels; and • Develop contingency plans that meet the Reproductive health service needs of survivors of gender-based violence in crisis situations and internally displaced persons.
National priority: A peaceful and progressive country where women and men enjoy security, equal rights and opportunities in all aspects of life **UNDAF outcome: Social equity of women, youth and minorities and vulnerable populations is increased through government's improved and consistent application of principles of inclusion in implementing existing and creating new policies and legislation**		
Outcome 2: Adolescents and youth: Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and Reproductive health	**Output:** Increased national capacity to conduct evidence-based advocacy for incorporating the rights and needs of adolescents and youth in national laws, policies and programmes, in particular healthy family life education and youth-friendly services	• Develop and implement advocacy strategies that involve youth and adolescent networks to incorporate their needs into national and sub-national strategies, service delivery packages, and budgets, in partnership with the Deputy Ministry of Youth Affairs; • Support the Ministry of Education and the Ministry of Health to design and implement community and school-based healthy family life education; • Advocate for and build institutional capacity to design and implement comprehensive programmes to prevent child marriage and adolescent pregnancies for vulnerable groups; and • Strengthen capacities of selected national/ subnational health facilities to provide rights-based, youth-friendly reproductive health information and services for married and unmarried girls.
Outcome 3: Gender equality and women's empowerment: Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth	**Output:** Strengthened capacities of health sector, and law-enforcement bodies for the prevention, response and monitoring of gender-based violence and child marriage in targeted provinces	• Support the adoption and use of protocols and monitoring tools, in line with international standards; • Develop capacities of health and police institutions by training health service providers, law enforcement bodies, and communities to prevent and respond to GBV, and care for survivors; • Integrate GBV response within the Reproductive health services of public institutions; • Mobilize and sensitize social structures, including those of opinion leaders, religious leaders, customary law institutions, and men and boys on the need for prevention of child marriage and GBV, and for support to gender-based violence survivors; and • Strengthen the multisectoral, coordinated GBV response in humanitarian settings.
National priority: Strengthen democratic processes and institutions, human rights, the rule of law, delivery of public services and government accountability **UNDAF Outcome: Improved legitimate, transparent and inclusive governance at all levels that promotes progressive realization of human rights**		
Outcome 4: Population dynamics: Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, Reproductive health and reproductive rights, HIV and gender equality	**Output 1:** Increased availability of national and local data, disaggregated by sex and age, to formulate, implement and monitor policies and programmes	• Support the Central Statistics Office to plan and conduct national and provincial SDES in the remaining provinces and the Demographic Health Survey 2015-2016; • Strengthen national and subnational capacities to collect and analyse sociodemographic data; and • Strengthen government capacity to collect and use data in humanitarian settings.
	Output 2: Increased capacity of government counterparts, parliamentarians and academic institutions, in data utilization and advocacy for policy development, planning, and monitoring of programmes on youth, gender equality and reproductive health.	• Support the use of policy-oriented research on population and demographics, poverty, Reproductive health and women's, youth and girls' empowerment; • Build national and subnational capacities of statistical offices, relevant ministries, and academic and research institutions to analyse, use and disseminate disaggregated data; • Partner with parliamentarians and religious leaders for evidence-based advocacy; • Strengthen information management systems on health and GBV and subnational capacity to use data in emergency preparedness and response; and • Support existing coordination mechanisms for data availability.

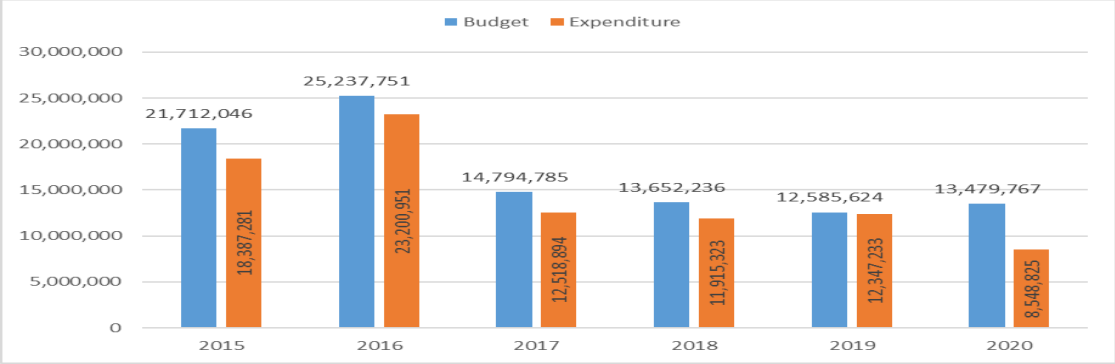
The UNFPA Strategic Plan 2018-2021 Business Model classifies Afghanistan as a least developed country (LDC) and is in the red quadrant with the focus on an enabling environment and on institutional and individual levels due to the extent of need, government inability to finance and the existence of humanitarian crises. It is based on this background that all the five modes of engagement, i.e. advocacy and policy dialogue, capacity development, partnerships and coordination with a considerable level incorporation of the South-South Cooperation, knowledge management and service delivery were adopted as the guiding implementation strategies across the CP outcome areas[60]. The full list of Atlas projects is annexed.

3.2.3 The CP Financial Structure of the Programme

At the time of programme design, UNFPA proposed $82.0. million (Regular Resource US$ 32 million and Other Resources US$ 50 million) for the execution of the 4th Afghanistan Country Programme over the first five-year period 2015 to 2019[61]. Upon extension of the programme from 2020 to 2021, the CP's budget was further projected by US$ 29 million (Regular Resource USD 7 million and Other Resource USD 22 million)[62].

From the financial records of the programme accessed, the resources mobilized in the first five-year period starting 2015 to 2019 was US$ 87,982, 443 (US$22,119,488 from Regular sources, with 65,862,955 from other resources), which is 7.3% more than the anticipated CP assistance. Figure 3.1 shows the evolution of the overall budget and expenditure of the CP from 2015 to 2019. This is further represented in Table 3.1 showing the budget utilization rates across the years of programme implementation.

Figure 3.1: Overall 4th CP Budget and Expenditure Evolution in US$ from 2015 to Sept 2020[63]



Source: UNFPA Afghanistan

Table 3.1 below, shows the overall budget utilization rate for the CPE period ending September 2020 is 85.7.1%, with the highest budget utilization rate being in 2019 at 98.1%, and the lowest being in 2017 (taking a full year's utilization) at 84.3%.

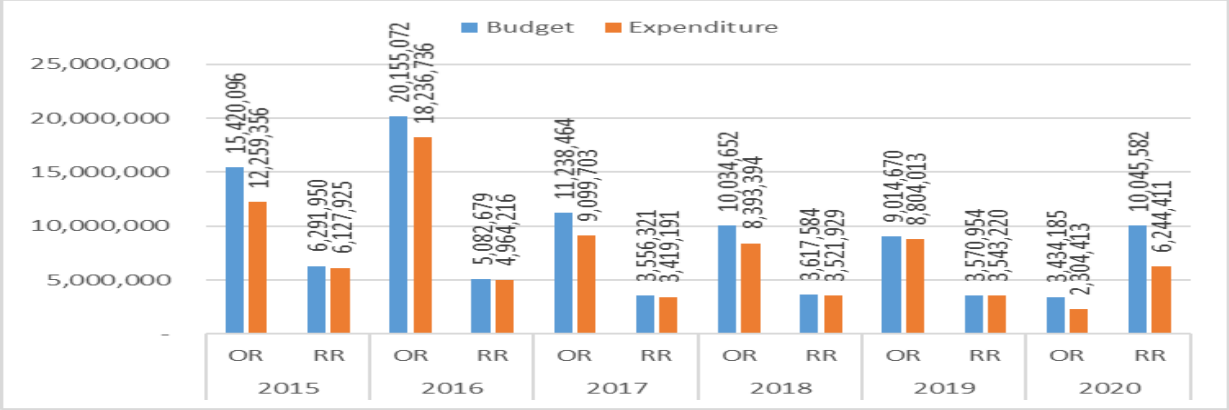
Table 3.1: 4th CP Budget Utilization rate January 2015 – September 2020

	Budget	Expenditure	Utilization Rate (%)
2015	21,712,046	18,387,281	84.7
2016	25,237,751	23,200,951	91.9
2017	14,794,785	12,518,894	84.6
2018	13,652,236	11,915,323	87.3
2019	12,585,624	12,347,233	98.1
2020	13,479,767	8,548,825	63.4
Total	**101,462,210**	**86,918,507**	**85.7**

[60] UNFPA Strategic Plan 2018 – 2021 – Business Model
[61] UNFPA 4th CPD 2015 - 2019
[62] CPE ToR, 2020
[63] **Source**: UNFPA Afghanistan

Source: UNFPA Afghanistan

Figure 3.2: 4th CP Yearly Budget and Expenditure by Source of Fund



Source: UNFPA Afghanistan

Table 3.3 shows the allocation and proportion of budget allocation to the programme areas in the first five years of the CP implementation ending September 2020. From Table 3.3, it is evident that the RHR component received the highest allocation of the resources at 40%, followed by Population dynamics components at 27%, then 27% was allocated to GEWE; while Adolescents and Youth component got only 5% and programme coordination and assistance (PCA) got 1%.

On the other hand, the allocation across the CP components also varied in the years. The table below shows the budget allocation for the resources acquired during the years per programmatic area of the 4th CP, in addition to the expenditures across the programmatic areas.

Table 3.3: Total Budget allocation and expenditure for the Programme Areas for the period 2015 – Sept 2020

Programme Area	Budget(US$)	Expenditure (US$)	% Allocation
Reproductive Health and Rights (RHR)	41,268,242	34,481,201	40
Adolescent and Youth (A&Y)	4,691,258	4,273,654	5
Gender Equality and Women's Empowerment (GEWE)	27,618,436	23,725,567	27
Population Dynamics (PD)	27,321,307	23,923,817	27
PCA	562966.1	514,269	1
Total	101,462,210	86,918,508	100

Source: UNFPA Afghanistan

CHAPTER 4: FINDINGS: ANSWERS TO THE EVALUATION QUESTIONS

4.1 Introduction

This chapter presents the findings of the 4th Country Programme Evaluation, in compliance with the UNFPA Evaluation Handbook on how to conduct Evaluation. It involves addressing the evaluation questions in relation to the evaluation criteria. The findings have been guided by the evaluation matrix, triangulating multiple data sources as elaborated in the methodology design. The extent to which the results have been realised is described in the text, with some generalized for the interventions of the 4th CP as the feedback is based on opinions expressed on the performance of the programme, especially on the result areas and respective interventions implemented.

4.2 Relevance

EQ1: To what extent is UNFPA support in the fields of RH and rights, youth development, population and development, and gender equality (i) adapted to the needs of the population, particularly of the most vulnerable and marginalized, ii) adapted to priorities or shifts caused by crisis or major political change and (iii) in line with the priorities set by the national policy frameworks?

EQ2: To what extent is the Country Programme (2015-2019 and its extension to 2021) aligned to the UNFPA Strategic Plan 2018-2021 and One-UN Mutual Accountability Framework 2018-2021, and Sustainable Development Goals?

Summary of Findings: The 4th CP was fully relevant and strategically aligned to national and international development needs. The design was well adapted to the needs of the population, particularly of the most vulnerable and marginalized, responded to the government priorities as contained in the Afghanistan National Development Strategy 2008-13 and is still aligned to the Afghanistan National Peace & Development Framework (ANPDF), national sectoral ministry strategies and the National Priority Programmes. The CP was fully aligned to the UNFPA global Strategic Plan 2018 – 2021, and UNDAF, later One-UN accountability framework. The CP is also aligned to the ICPD Programme of Action and SDGs (especially 3, 5, 10 and 17). There is evidence of design and implementation of the programme in consultative manner with the participation of the government, advancing national ownership and capacity building. The 4th CP was responsive to changing national needs and environment especially in the increasing displacement, returnee influx, COVID-19, floods and drought. UNFPA is seen as a highly respected and valued partner in both national and county levels of government and among other stakeholders. During the 4th CP, the UNFPA developed innovative partnerships, including with the National Parliament, facilitating advocacy mechanisms leading to enactment of laws in the country. However, there was little evidence on how the design of the CP benefited

from consultations of the most vulnerable and marginalized populations to effectively reflect on their needs.

4.2.1 The Strategic Relevance

4.2.1.1 Alignment to the UNFPA Strategic Plan

The development of the 4th UNFPA Country Programme (CP) was done in line with the UNFPA Strategic Plan 2014 – 2017, and later realigned to the Strategic Plan (SP) 2018 – 2021 (document review and Interviews). From analysis of records and interviews, the CP contributes directly to the four thematic result areas covered by the SP. The realignment saw incorporation of the three UNFPA transformative results, of ending preventable maternal deaths, ending gender based violence and ending unmet need for family planning as well as the 2030 Sustainable Development Agenda (Document review and Interviews with CO staff).

The CP components directly contribute to the achievement of the SP overall goal aimed at achieving universal access to Reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the (ICPD) agenda, to improve the lives of adolescents, youth and women, enabled by population dynamics, human rights, and gender equality.

Further alignment of the 4th CP to the SP is exhibited by the reporting systems, with the results of the CP being reported and represented in the Strategic Information System (SIS), where the outputs are covered according to the SP. In compliance with the SP business model, where Afghanistan is classified in the red quadrant, representing least developed country (LDC)[64], UNFPA Afghanistan employed all the five modes of engagement (partnership and coordination, knowledge management, advocacy and policy dialogue, capacity development and service delivery) in the delivery of the CP. Contextually, the modes of engagement are relevant as later described in this section of the report when assessing the relevance of the CP in addressing the population needs and national priorities. While the definition of the results in the CPD still reflected those of the Strategic Plan 2014 – 2017 including the IP AWPs, document reviews and interviews with staff revealed that the implementation framework, including reporting (SIS and GPS) reflected the new SP outputs. The structuring of the result areas in the reviewed documents was also still not aligned to the Strategic Plan 2018 – 2021 (SP). There was also no detailed information on how the realignment took place to reflect on the new development, much as the realignment was reflected in the interventions of the country programme.

4.2.1.2 Alignment with ICPD PoA and SDGs

Reviews of programme reports and interviews with CO staff indicate that the design and implementation of the 4th CP is evidently grounded and guided toward the achievements of the International Conference on Population and Development Programme of Action (ICPD PoA). The programme's focus on increasing access to skilled birth attendance in the country, specifically targeting the hard-to-reach areas, access to a full range of reproductive health services, including family planning; (document review and interviews), directly contributes to the ICPD PoA goals.

From analysis of programme reports and interviews with CO and GoIRA staff, the CP contributed to the achievement of the SDG 3 (Good health and wellbeing); SDG 5 (Gender equality); SDG 10 (Reduced inequalities); and SDG 17 (Partnership building); and to some extent SDG 4 (Inclusive and equitable quality education) and SDG 16 (Peace, Justice and Strong institutions). The CP was aligned to the SDG 3 by increasing access to quality RH services through supporting technical and financial assistance on RH (establishment of Family health houses, midwifery helplines, and Obstetric Fistula care), training of midwives for skilled birth attendance, and strengthening access to family planning services through demand creation. Towards SDG 5, the CP addressed GBV response and prevention, elimination of harmful practices like child and forced marriage, strengthening advocacy on addressing gender issues in the country, and increasing

[64]Afghanistan is classified as a least developed country by the UN due to her low development indicators, in addition to unavailability of clear information on development in the economy. Accessed from: https://unctad.org/en/pages/aldc/UN-list-of-Least-Developed-Countries.aspx

women's right in making decision through strengthening Health Sector Response to GBV, Police Sector Response to GBV, GBV SC and pre-marriage counselling. On SDG 10, the CP addressed issues of inequalities, by increasing focus on the marginalized populations in the hard-to-reach areas and increasing their access to RH services, supporting advocacy mechanisms that promote equality and eliminates discrimination, especially for women and girls and people with disabilities and provision of data on access to services by those in humanitarian crisis. The CP utilized multi-stakeholder engagement through partnership and supporting coordination mechanisms in its delivery, thereby contributing to SDG 17. In addition, UNFPA utilized partnerships in the implementation of the CP interventions.

The UNFPA 4th CP contributed to SDG 4 through supporting and contributing to mechanisms to ensure adolescents, youth and women are empowered and equipped with increased skill-based and life skills knowledge, among other endeavours to strengthen integration of family life education into the primary and secondary school curriculum. The programme also contributed to SDG 16 through strengthening access to justice systems, especially for the people whose rights are violated and strengthening institutions in the country. UNFPA also contributed to strengthening institutions through development of various strategies, mainly the National Youth Strategy and Youth Policy which incorporated and clearly defined the needs of the youth and how to respond to them, including their role in peacebuilding. Effectively implemented, the strategy and policy will go a long way in strengthening the country's roadmap to youth empowerment and meaningful engagement in governance and state building.

4.2.1.3 Alignment to UNDAF 2015 – 2019 and One-UN Mutual Accountability Framework 2018-2021

The design and implementation of the 4th CP is fully aligned to the United Nations Development Assistance Framework for Afghanistan (UNDAF) 2015 – 2019. From document reviews, the 4th UNFPA programme contributes to four out of the five priority areas of the UNDAF through the pillars of basic social services (Pillar II), social equity and Investment in human capital (III), justice and rule of law (IV), and accountable governance (V). Towards realignment of the UN work in Afghanistan with the national priorities in the Afghanistan National Peace and Development Framework (ANPDF), the One-UN document 2018 - 2021 was launched replacing UNDAF 2015 - 2019. To ensure further realignment with the One-UN framework 2018 - 2021, UNFPA extended the CP period by two years to align with the extension of the UN mission in Afghanistan. There are numerous mechanisms indicating the 4th UNFPA CP alignment and direct contribution to One-UN framework. Evidence from the interviews[65] and document reviews[66] indicate that UNFPA directly contributes in its areas of responsibility in the One UN framework. There is also evidence of UNFPA collaborating and implementing joint programmes with other UN agencies to deliver their mandate, directly contributing to the national priorities which the One-UN framework is about as detailed in the Section 4.6. UNFPA is a member, and actively participates in a number of coordination mechanisms within the UNCT, in addition to co-chairing some of them such as leading youth inter-agency working group, health pillar, data for development committee, and GBV sub-cluster. While the CP if directly aligned with the One-UN framework, there are general issues of inadequacy of capacity and resources among the government institutions and bits of overlaps among the UN agencies, UNFPA included, especially in health and gender mandates; and insecurity that affect effective delivery of the UN mandates in the country.

4.2.2 Relevance of the Country Programme to the National Priorities and Population Needs

Interviews and document reviews indicate that the development of the 4th UNFPA CP took into considerations the national priorities as stated in the Afghanistan National Development Strategy 2008-13 and is still aligned to the Afghanistan National Peace & Development Framework (ANPDF)[67] and national sectoral ministry strategies. In addition, the CP is aligned with the Na-

[65] Interviews with Resident Coordinator, UNICEF, WHO, UNFPA, UN Women

[66] UNDAF documents, UNDAF MTR, CPD and Reports

[67] Afghanistan National Peace & Development Framework (ANPDF) 2017 - 2021

tional Priority Programmes through strengthening capacities and institutions to provide improved service delivery and sustainability in the areas of responsibility (interviews and document review). In the design of the 4th CP, the support is provided in provinces with high rates of poverty and maternal and infant mortality, showing its relevance (document review). Further, the decisions to target the adolescent and youth, gender equality and women's empowerment, and the population dynamics interventions were majorly based on felt needs as identified through consultations among the relevant stakeholders, including targeted beneficiaries, assessments, programme reviews, among other contextual determinants, for example the need to engage the youth on state building, socioeconomic empowerment, among others. There is also evidence that UNFPA held consultations with various stakeholders including government line ministries, taking into consideration their opinions on the existing development challenges and designing their suggested solutions (Interviews with CO staff and IPs). It is evident from the CP results and resource framework (RRF) that the programme directly contributes to three national priority areas through the components of RH, enhancing adolescents and youth participation in the development of the nation, contributing to ensuring a society that upholds gender equality, dignity, respect and fairness for all women and men, and through strengthening accountability in the public sector by availing data for decision-making. Interviews with the CO and IP staff also stated that the CP was highly informed through consultations of the vulnerable populations. For example, in the identification of the FHH location entailed consultations of the locals who guided the on the establishment of the facilities in their localities. Further interviews with the CO staff revealed that development of the CP was informed by past experience in the previous CPs, in addition to the contribution on the UNDAF, developed from consultations of the targeted government entities and populations, including vulnerable persons in need of the services. Feedback from the health IPs, MoPH and WHO showed that UNFPA interventions were designed to complement the government policies and strategies. For example, this is evidenced in the establishment of FHH in areas not targeted by the BPHS to enhance service delivery in provision of maternal health; and the health sector approach to GBV has elicited the practice as a violation of human rights and operationalized in the national health strategy. The relevance of the 4th UNFPA CP is also grounded on the contextual understanding, including incorporation of the Islamic values and local engagement in its implementation. For example, towards increasing the uptake of family planning in the country, UNFPA supported review on FP strategy to incorporate Islamic approach to family planning, in addition to engaging Islamic religious scholars and leaders and making the approach contextual by referring to family planning as birth spacing. UNFPA also grounded the CP approach to addressing GBV and adolescent RH based on human rights and gender equality principles, incorporates Islamic values in addressing the needs. Afghanistan faces prolonged and protracted emergencies, with chronic and acute displacement of people from their places of origin. While this is the case, the country does not have the preparedness plan and capacity to deal with the situation, in addition to providing services to the people affected. During the 4th CP, UNFPA contributed to strengthening the capacity of the stakeholders in the humanitarian response led by the MoPH and ANDMA, in addition to supporting the two units both financially and technically in the development of emergency preparedness plans at the MoPH, and the overall plan for the ANDMA, contributing to the address of the emergency situation in the country, with UNFPA leading on the inclusion in addressing the RHR and GBV needs of affected women and girls during disasters and emergency situations (interviews with CO staff and MoPH).

4.2.2.1 Reproductive Health

Afghanistan has high total fertility rate (5.1 children per women) coupled with lowest contraceptive prevalence rate (less than 20 percent for all methods) and high unmet need for family planning (25 percent). To address these gaps, UNFPA 4th CP effectively advocated with religious leaders, community elders and the population to create demand for family planning services. UNFPA also built the capacity of public and private health service providers to enable them to tackle the supply-side challenges related to family planning. In addition, UNFPA provided family planning commodities (contraceptives, supplies, and equipment).

At the strategic level, UNFPA 4th CP addressed the capacity gaps through provision of technical support to the Ministry of Public Health and the implementing partners. To clarify, the UNFPA 4th CP had relevant contribution to the policy development and national institutional and human resources capacity development. Further, UNFPA in the 4th CP focused its technical and financial support on the development of various policy documents such as the revision of RMNCAH strategy, development of Family Planning Costed Implementation Plan, SBCC strategy for Family Planning, and family planning training package targeting various stakeholders (Interviews with CO, MoPH and IP staff). In addition, UNFPA contributed to the revision of the midwifery training curriculum at KU to provide bachelor degree, development of reproductive health commodity security learning resource package (RHCS-LRP), and development of orientation package for community gatekeepers (document review and Interviews with CO and MoPH).

In order to contribute to the reduction of maternal and infant deaths in Afghanistan, UNFPA increased access to skilled birth attendance to the marginalized and hard-to-reach populations by technically and financially supporting the training of midwives, establishment of FHH, mentorship of midwives, training and development of technical guidance. This was done in collaboration with the Community-Based Health Care (CBHC) and Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) departments of the MoPH to improve the health and well-being of communities living in white areas (Interviews with CO, MoPH and IP staff).

Access to advance maternal health services especially fistula care was not available in the country. In addition, the fistula survivors had poor socio-economic conditions including not having access to transportation for seeking health care for their obstetric fistula. UNFPA 4th CP supported the government in the establishment of OF wards, building the capacity of local surgeons together with transfer of skills to the provincial levels, availing equipment and drugs to the OF wards, and provision of transportation and accommodation allowances to the survivors (CO reports and interviews with CO, MoPH and Malalai Maternity OF staff). UNFPA is the only entity in Afghanistan that ensured advanced health services for obstetric fistula survivors and this makes the contribution relevant to the needs (Interviews with CO staff and MoPH).

4.2.2.2 Adolescent and Youth

UNFPA in the 4th CP prioritized to work with DMoYA by supporting it in the development of the National Youth Strategy and National Youth Policy aiming to bring out the meaningful involvement of the youth in the country to empower them socio-economically at national level. This contribution enabled focusing on the youth in various ways by the national youth stakeholders, led by the government, providing guidance of the youth-targeted programmes in the country, addressing evidenced needs as identified through assessments, consultations and gaps identified during implementation. Through the YP, the youth contributed to the content of the strategies, in their participation during the development processes. This support filled the gap in structuring youth engagement in the country, which never used to exist, making the relevant in addressing the felt needs. Implementation and identification of resources for the strategy was though reported to be a challenge, in addition to slow decision-making as it involves seven line ministries (Interview with UNFPA CO staff).

UNFPA contributed in addressing this through the development of the National Action Plan on Elimination of Child Marriage, aiming to eradicate the practice, making it relevant in the context of implementation. In addition, UNFPA financially and technically supported DMoYA in the implementation processes through strengthening their identified needs in capacity and advocacy in resource allocation for its implementation (Interviews with the DMoYA, MoPH and UNFPA CO staff).

During the 4th CP, UNFPA technically and financially supported the review of the RMNCH strategy to include the adolescent Reproductive health (ARH), addressing the gaps in targeting the young people with services, in addition to capacity building of the healthcare workers to provide ARH services and advocate for the rights of the young people's rights to information on the same (Interviews with MoPH, IPs and UNFPA CO staff). In response to the needs of the ARH needs of the young people in the country, identified through their consultations, UNFPA supported the MoPH both technically and financially to pro-

vide youth health line (YHL) and youth health corners (YHC) which increases the youths and adolescents access to youth-friendly ARH across the country (Interviews with IPs, CO staff, UN agencies and SIS). Through giving orientation to community gatekeepers and CHWs and strengthening PEER education networks, UNFPA 4th CP helped to increase communities' awareness and demand to utilize youth friendly ARH services.

Recognizing the gaps that exist in the country where young people are not involved in state building, governance, peacebuilding and without empowerment, UNFPA, in the 4th CP, supported the establishment of Youth Parliament and advocated for its inclusion in the Upper house of the National Parliament to give voice to the needs of the youth and provide linkages that seek to recognize the young people as key contributors of country's development and in the humanitarian process. UNFPA worked with DMoYA to effectively advocate at national level on behalf of youths on their needs such as employment opportunities, capacity building and participation. These confirm it relevance in contributing to the needs of the youth while at the same time contributing directly to the DMoYA strategies.

4.2.2.3 Gender Equality and Women Empowerment

To address gender inequality in Afghanistan, UNFPA is taking lead in technically and financially supporting conducting advocacy to increase women and girls' access to their fundamental rights, including their space to make meaningful decisions without being discriminated against through strengthening health sector response to GBV, capacity building of the police on GBV, and upstream and downstream advocacy on women's empowerment. In addition, UNFPA is collaborating with other stakeholders to provide support to the survivors of GBV to get assisted, like the legal and medical services that the CP is not providing (Document review and Interviews with CO, IP, UNICEF, and UN Women staff).

Interviews with MoPH, MoI and CO staff confirmed that the 4th CP GEWE component interventions were implemented based on priorities identified at the annual review and planning meetings with participation of the national stakeholders, including the line ministries, CSO, donors and IPs. There was also evidence of consultations identifying gaps through community level engagements, including the marginalized and vulnerable populations, government requests, gender-based violence (GBV) sub-cluster coordination, referrals within the affected communities, GBV information management systems (GBV IMS) data which also informed decisions based on the cases reported (Interviews with MoPH, IP and CO staff).

UNFPA in the 4th CP contributed immensely to addressing resource constraints by coordinating resources leveraging and mobilization as the co-lead of the GBV sub-cluster[68], in addition to coordinating service delivery among the various stakeholders ensuring that priority gaps were filled, in addition to minimizing overlaps. Through the GBV sub-cluster, advocacy mechanisms were enhanced to ensure the identified gaps in case management across the country, and to support advocacy on elimination of harmful social and cultural practices. UNFPA also finances the management of GBV data through the GBV IMS which informs decisions by the presenting the prevalence of the various forms of violations generated on a monthly basis, including advocacy mechanisms, and is able to estimate the level of performance trends since there are inadequate mechanisms for monitoring and data collection on GBV (Document review and Interviews with CO, IP, UNICEF, and UN Women staff and Sub-Cluster members).

UNFPA through its Gender Component in partnership with the Government of Afghanistan is contributing immensely to strengthening the referral mechanisms through the establishment and support to Family Protection Centres (FPCs) in the provincial health facilities to enable documentation, psychosocial support, legal counselling and referral; and Family Response Units (FRUs) in the police stations for justice access by the GBV survivors. UNFPA also supported the line ministries, particularly, the MoPH and MoI, enhancing their capacities to enable response and strengthened case management process, in addition to prevention and monitoring of GBV and child marriage

[68] UNFPA through the sub-cluster coordination ensure that there was no overlap among the responders to GBV through mapping of partner presence with the services that they are providing. In addition, the coordination mechanisms ensured that the GBV needs were included in the HNO and HRP.

(Document reviews and interviews with CO, MoI, MoPH and IP staff).

UNFPA 4th CP supported the government to adopt services and policies for the provision of RH services for women in humanitarian plans and responses. At the service delivery level, UNFPA fulfil the gaps through provision of emergency reproductive health kits in crisis affected areas, development and adoption of the MISP guidelines for the Afghanistan humanitarian context, and distribution of dignity kits to women of child-bearing age for hygienic needs in crisis affected areas. Similarly, UNFPA as a lead UN agency worked with the health cluster to make reproductive health services an integral part of humanitarian response. UNFPA helped to ensure that the specific needs of women especially regarding reproductive health are factored into humanitarian response planning. UNFPA 4th CP assisted the Afghan government in integrating the Minimum Initial Service Package (MISP) in humanitarian planning and action. Working with the Ministry of Public Health, UNFPA 4th CP developed a cohort of 100 health care providers as MISP trainers at the central and regional levels (Interviews with IPs, CO and MoPH staff).

4.2.2.4 Population Dynamics

The 4th CP Population dynamics (PD) component is aligned to the national needs addressing the existing gaps of data generation and development formulation and monitoring. Implemented in alignment with the ICPD PoA, the component directly contributes to the government's capacity in generation of data and strengthening advocacy on utilization of the data generated to inform development and policy formulation. This in turn informs evidenced-based decision-making and increases transparency and accountability in the delivery of services by the public and private institutions, and the development indicators are informed by availability of data from the support provided in the country by UNFPA. During the 4th CP, UNFPA technically and financially supported the National Statistics and Information Authority (NSIA) to conduct Sociodemographic and economic survey (SDES) in eight provinces, which contributed to the measurement of the social, demographic and economic indicators in the country, especially in the targeted provinces. The results of these surveys have been used to set baselines and assess performances of the various provincial development frameworks, among other related development strategies, as the surveys brought out the various developmental gaps in various sectors in the provinces (Interviews with CO, NSIA, and MoEC staff).

UNFPA, through partnership with Flowminder Foundation and University of Southampton supported the NSIA in development of high resolution satellite imagery to help in accurately map and estimate the country's population, including other development indicators. This has reliably provided a cheaper and accurate information on the population estimates, including projections, in the absence of census (document reviews and interviews with CO and NSIA).

With the longstanding conflicts and instability in the country, Afghanistan has, and continues to have glaring capacity gaps in statistics and demography, especially at institutional and individual levels. In the 4th CP, through partnerships and technical approaches, UNFPA strengthened the capacity of Kabul University (KU) department of Demography and Statistics of the Faculty of Economics through reviews of the curricula to incorporate demography in course content and produce specialist graduates in the same adding into the capacity of the country that only had two demographers (interviews with CO staff). UNFPA also contributed to strengthening the government institutional capacities, through support of the NSIA on data analysis and use of disaggregated data using the SDES data. In addition, UNFPA supported the establishment of data corners at the provincial levels to enable access to and use of data for planning and decision-making (interviews with NSIA and CO staff and document review).

UNFPA through its advocacy and support to the Ministry of Economics on the importance of use of populations data, financed and technically supported the development of the National Population Policy, for the first time, which at the time of the CPE was finalized and being prepared for presentation to the Cabinet Council for approval (Interviews with CO and MoEC staff and SIS). Approved and implemented, the policy will provide a framework for decision-making, especially on economic development; further informing enhanced advocacy on demographic issues and promote investment in social sectors to respond

to changes in population, like the fertility rates, youth numbers, among others, as guided by the policy, decisions that cannot be effectively made in the absence of the policy (interviews with MoEC and CO staff, and document reviews).

4.2.3 Country Programme Responsiveness to Emerging Needs

Review of documents and interviews with various stakeholders and staff indicated that UNFPA was very responsive and immensely contributed to the emerging needs in the areas of mandate during the 4th CP period. These were both in the development and emergency settings.

At the onset of COVID-19, UNFPA supported the MoPH in procuring personal protective equipment (PPE), including medical and non-medical supplies for healthcare workers in the maternity hospitals and wards, which ensured continued provision of maternal health services without interruptions, as their safety was assured (Interview with MoPH and CO staff). In addition, UNFPA also contributed to procuring COVID-19 infection prevention and control (IPC) knowledge materials and distributed to various maternity hospitals. During the same time, UNFPA established medical screening health teams at Mazar, Kundus, Herat, and Nimrose which entry point for COVID-19 from Iran). At the same time, UNFPA switched the community dialogue modality to radio spots in order to prevent spread of COVID-19 and still sensitize the negative perceptions of community towards women and GBV (Interview with MoPH and CO staff). At the request of the MoPH, UNFPA, for the first time, financed screening of more than 2000 newly joining school children on mouth hygiene, vision, hearing (Interviews with MoPH and CO staff).

With the unexpected influx of Afghan returnees from Pakistan and Iran, informed by joint rapid assessments on the needs on the respective areas of mandate, UNFPA reprogrammed its core resources and mobilized Central Emergency Response Fund (CERF) to provide emergency lifesaving RH services at the border entry points as well as in conflict-affected areas through mobile health teams, effectively providing integrated RH and GBV services to the returnees, in addition to establishment of two FPCs in district hospitals of Heart and Nimroz provinces to respond to GBV cases and provide health services to survivors. UNFPA also responded to IDP crises through establishment of another FPC in Kundoz province to help displaced persons. Staff of UNFPA's supported Women Friendly Health Spaces (WFHS, established near conflict area) along with Humanitarian Team conducted visits to remote areas, reaching people in crisis and identifying GBV cases (SIS and interviews with CO, MoPH and IPs staff).

To effectively fulfil the needs of populations during emergencies, UNFPA ensured that the reproductive health services were factored into the humanitarian response including the border areas (document review and Interviews with IPs and CO staff).

4.3 Effectiveness

EQ3: To what extent have the 4th CP outputs been achieved, and to what extent have these outputs contributed to the achievement of the 4th CP outcomes, including Humanitarian preparedness and response?

EQ4: To what extent did the country programme integrate a gender-responsive and human rights-based approach to programme planning, implementation, and monitoring?

4.3.1 Reproductive Health

Summary of Findings: The UNFPA 4th CP applied multipronged approaches, including a system-strengthening for increasing the demand for and enhancing access to family planning, increasing access to skilled birth attendance through establishment of FHH in the hard-to reach areas, midwifery mentorship, and support to midwifery association, education and regulation, treatment of obstetric Fistula by focusing on policy development, guidelines development, advocacy, evidence-generation, institutional and human resource capacity building to deliver RH services, mobilization of various societal structures and supply of RHCS, including strengthening supply chain management through logistics management information system (LMIS).

During the 4th CP, UNFPA played a critical role in strengthening the capacities of stakeholders and delivery of the RH and GBV services during emergencies and human crisis. The programme was recognized as an

important contributor in addressing the humanitarian needs in the country using human rights-based approaches to ensure access to services (Interviews with MoPH, UN agencies, IPs and beneficiaries). UNFPA supported the Afghanistan National Disaster Management Authority (ANDMA) to develop emergency preparedness plan for the country. Coordination of the humanitarian response in the country needs to be streamlined, especially government and OCHA at the provincial levels.

Introduction of the Component

The Reproductive health and rights (RHR) component of the UNFPA's 4th CP outcome was designed and implemented to ensure increased availability and use of integrated 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. The component has three distinct output results areas aimed at ensuring increased national institutional capacity to deliver a coordinated supply of modern contraceptives and improved quality of family planning services in selected provinces; deliver comprehensive maternal health services to underserved populations; and provide Reproductive health services in humanitarian settings (CPD). The component had two outcome indicators and eight output indicators as indicated in Table 4.1 below.

Achievements of Planned Component Results

As indicated in Table 4.1 below, UNFPA reached or on track to achieve all the planned targets set for the RH outcome, except the indicator under the family planning which had challenges in attaining. UNFPA made remarkable efforts towards improving the uptake of Family Planning services by the target populations through financially and technically supporting the development of the Family Planning Costed Implementation Plan (CIP) 2018-2021 and approved by MoPH, advocacy mechanisms, research and strategy development, capacity building of the healthcare workers targeting different sexes of the staff, especially aimed at improving male involvement, strengthening the logistics management information system for forecasting and monitoring family planning commodities and commodity supplies (Interviews with MoPH, IPs and Co Staff, and document reviews). It is however key to note that the CPR is still less than 20%, and has been like that for nearly 10 years, which was mainly due to low government commitment in the prioritization of FP activities, socio-cultural barriers, and supply-side challenges including family planning commodities stock out, among other contributing factors (Annual reports and interviews with IPs, CO and MoPH staff). There was improvement in access to skilled birth attendance through the establishment of more FHHs, than planned in five provinces namely Daikundi, Bamyan, Faryab, Herat and two MHTs in Ghor province, UNFPA having mobilized more resources during the period to expand to more provinces with the services, in addition to training of more community midwives and mentoring them to deliver quality services. Interviews with health stakeholders recognized the key role and contribution that UNFPA made in this area of focus (Annual Reports 2015 – 2019 and interviews with IPs, MOPH and CO staff)).

At the output level, all the indicators reached their targets, except one on staff trained on MISP, with some indicators exceeding the targets. For example, for ensuring proper forecasting and monitoring of family planning commodities, the healthcare workers trained on the logistics management information system (LMIS) were from 30 provinces as planned. Similarly, in order to make sure that quality family planning services were provided, UNFPA built the capacity on healthcare workers based on WHO criteria specifying quality guidelines and monitoring feedback indicated that the services provided on FP met the quality standards (annual reports and midwives, CO, MoPH and IP staff). Besides, to address the skilled birth attendance needs of populations in the marginalized areas, UNFPA supported establishment of more FHH in the hard-to-reach locations, increasing coverage and enhancing access to services by the women of reproductive age (SIS data and Interviews with CO, IPs and MoPH staff, and trained midwives). UNFPA strengthened treatment of obstetric fistula during the 4th CP through training healthcare workers on identification of the cases, surgeons on basic surgery, expansion to two health facilities, renovation of wards and equipping the theatres for the same, in addition to supporting the survivors and caregivers' accommodation and transport, and social reintegration of the survivors

UNFPA contributed to the country's humanitarian response through financially and technically supporting strengthening of the response systems including leading sub-cluster coordination, partnership with ARCS with national coverage, capacity building, supporting response strategy development, evidence-based response through contributing to HNO and HRP, RH commodities and dignity kits distribution during emergencies, and service delivery mechanisms during emergency crisis integrating GBV, RHR and psychosocial support (Annual reports and interviews with CO and MoPH staff).

Table 4.1: M&E Framework for the Reproductive Health component of the 4th CP

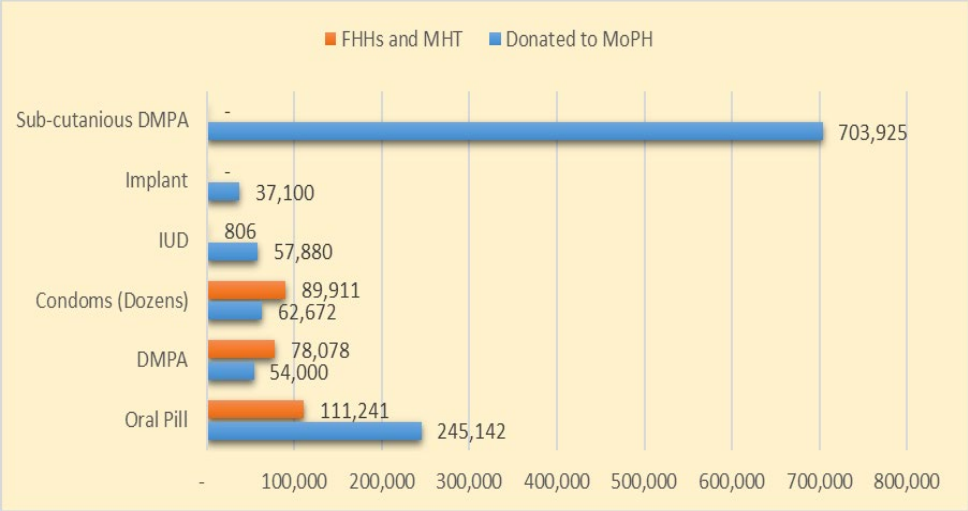
UNFPA Strategic Plan outcome: Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated Reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence				
Indicators	**Baseline[69]**	**Targets**	**Achievements[70]**	**Comments**
Percentage of skilled birth attendance	40%	60%	58.8%[71]	This indicator is on track. UNFPA contributed to this national outcome indicator through technical and financially supporting strategy development, research, advocacy, guidelines and service delivery.
Prevalence of modern contraceptive use	22%	34%	17.4%[72]	Despite the progress made in addressing challenges associated with uptake of family planning services, the Contraceptive Prevalence Rate (CPR) has not improved since 2010. The CPR has stagnated at less than 20 percent (AMS 2010 reported 20 while AfDHS 2015 reported the 23 per cent). To find out the causes, UNFPA, in collaboration of the MoPH, conducted the two important demand and supply side studies to explore the determinant of low CPR to inform the evidence-based policy decision.
Output 1: Increased national institutional capacity to deliver a coordinated supply of modern contraceptives and improved quality of family planning services in selected provinces				
Number of programme/policy guidance documents on family planning developed and disseminated	3	6	12	Target surpassed. There was however reported gap(s) in the implementation of the policy/ guidelines or tools with some mostly citing inadequate resources and capacity by the MoPH.
Number of provinces trained on LMIS for forecasting and monitoring family planning commodities	10	30	30	The capacity was built on the Channel software but there was no evidence if the system was used, as the BPHS and EPHS implementing NGOs forecast and procure their pharmaceuticals including RH supplies and contraceptive commodities through their own individual bulk procurement mechanisms from the open market. The implementing NGOs do not use the LMIS.
Number of health workers trained to provide family planning services that meet human rights standards and WHO criteria	269	1,500	5503	There is over achievement in this indicator. It is cumulative achievement over the 4th CP period.
Output 2: Increased national institutional capacity to deliver comprehensive maternal health services to underserved populations				
Number of family health houses established with functioning competent community midwives	82	126	146	There was overachievement due to mobilization resources for extra FHH by the CO.
Number of women who received pelvic floor disorder repair surgeries (specifically obstetric fistula)	62 per year	150 per year	854	Since the figure is cumulative for five years, the average achievement (171) in the indicator surpasses the yearly target.
Number of midwives trained using policies and revised curriculum that meets International Confederation of Midwives WHO standards	0	100	301	The need of population and funding availability ensured overachievement in this indicator. This data is for 2018 and 2019 only.
Output 3: Increased national capacity to provide reproductive health services in humanitarian settings				
Number of competent personnel delivering the minimal initial service package	150	390	260	The target in this was not achieved, but there was progress from the baseline.

[69] Baseline as at December 2014
[70] Service data on the indicators is up to December 2019
[71] Afghanistan Health Survey (AHS) 2018
[72] Afghanistan Health Survey (AHS) 2018

National and provincial contingency plans developed and used to address reproductive health needs for women, youth and adolescents, including services for survivors of sexual violence in crises, persons with disabilities and internally displaced persons	0	5	5	UNFPA technically and financially supported the country in development of contingency plans for response in case of an onset of emergency, and were reported to be in use by the CO and MoPH staff. GBV contingency plans for various regions were also developed, shared and used by cluster members.

4.3.1.1 Strengthened capacity to deliver a coordinated supply of modern contraceptives and improved quality of family planning services

Increased demand for and access to quality family planning services



The UNFPA 4th CP applied multipronged approaches for increasing the demand for and enhancing access to family planning by focusing on policy development, evidence-generation, institutional and human resource capacity building, mobilization of various societal structures and supply of family planning commodities including strengthening supply chain management through logistics management information system (LMIS).

UNFPA provided policy level support in family planning through the development of various strategic documents. In fact, UNFPA technically and financially supported the revision of RMNCAH strategy, developed family planning training package targeting various stakeholders and family planning orientation package for civil society, developed RHCS learning resource package, developed orientation package for community gatekeepers (Document review and interviews with MoPH, WHO, CO and IP staff). In addition, the 4th CP supported the Ministry of Public Health in the development of various policy and programme documents related to Family Planning and rolled out. The documents were CHW training package on counselling and DMT, RHCS Learning Resource Package, Family Planning national guideline, Community Health Workers (CHW) Learning Resource Package on FP counselling and CHW Decision Making Tool on family planning, Religious leaders Training Package, Contraceptives Medical Eligibility Wheel 2015, FP Global handbook for service providers, and Family Planning Costed Implementation Plan. There was however inadequate commitment form the MoPH in prioritizing FP, inadequate resources and capacity in the implementation of these policies (Document review and interviews with MoPH, IPs, WHO and CO staff).

Figure 4.1: Contraceptives distributed through UNFPA 2015-2020

Despite the progress made in family planning in Afghanistan, the Contraceptive Prevalence Rate (CPR) has not improved since 2010. The Afghanistan Mortality Survey 2010 reported that CPR was 20 percent and the same figure was reported by Afghanistan DHS 2015. To provide evidenced-based programming on family planning in Afghanistan, UNFPA in collaboration with the Ministry of Public Health conducted two important demand- and supply side studies. On the supply-side issues, UNFPA conducted the comprehensive family planning needs assessment in Afghanistan. Based on the results of the supply-

side study, UNFPA supported the Ministry of Public Health technically and financially to develop the Family Planning Costed Implementation Plan (CIP) for five years, with the aim of improving the family planning programme design and implementation leading to the improvement of the CPR. UNFPA further supported the development of the FP implementation monitoring tools to ensure that the FP CIP was implemented (Interviews with MoPH and CO staff and document reviews).

Understanding the demand-side entailed UNFPA supporting the MoPH in conducting a family planning behavioural study on use and non-use of contraceptives. With the results of the FP behavioural study, UNFPA supported the MoPH to develop a five-year social behaviour change communication (SBCC) strategy[73] to promote use of contraceptives. Further, to increase awareness on FP, UNFPA supported a nation-wide survey on social media promotion of FP. The SBCC strategic plan provided a framework for addressing the socio-cultural barriers on the uptake and use of contraceptives in the country through identifying the influences, knowledge gaps and defining key communication strategies based on targeted audience and information sharing with the general population. This further aimed at enhancing demand creation mechanisms for the contraceptives and guided the FP promotion and service delivery at national, regional and provincial levels (Interviews with MoPH and CO staff and document review). The SBCC enhanced the engagement of key stakeholders including religious leaders, community leaders, teachers, women groups, and youth through use of different communication strategies to advocate for increasing the uptake of FP among the women of reproductive age (Interviews with MoPH and CO and document reviews).

UNFPA strengthened sensitization and mobilization of various key actors to promote FP in their societies and dispel the myths and misconceptions regarding FP through orientation of the Community Development Council members, Journalists, Health *Shura* members, Youth Activists from different provinces on the misconceptions against family planning. These groups were the key influencers which took the messages on family planning further to their communities for increasing the demand and enhancing the utilization of contraceptives (Interviews with IPs and CO). In addition, UNFPA supported training of 784 community gatekeepers and civil society activists including journalists, head of community Health committees (Shuras), youth activists, women civil society leaders, and orienting the religious leaders on FPin the target five provinces (Annual Reports and Interviews with CO and IPs) to improve demand and address social, cultural, and religious barriers against utilization of family planning. Similarly, audio and video messages were also developed on FP, which were focused on newly married couples, mothers-in-law and religious leaders. These messages were broadcasted through radio and social media campaign in various social media pages (Facebook, Instagram, and twitter) (Interview with IPs and CO staff and reports review). UNFPA also contributed to enhanced demand for family planning through the development and dissemination of information, education, and communication (IEC) and other knowledge materials as evidenced by 11.9% increase in the number of FP clients in 2019 (SIS 2019).

UNFPA was active in different coordination platforms at the national and subnational levels for the support of RH services such as RMNCAH coordination committee, RHCS coordination committee, MNH technical working group, family planning technical working group, and Maternal and Newborn Deaths Surveillance and Response (MNDSR) working group. UNFPA's active role in these coordination forums, effectively contributed to the transfer of technical skills and knowledge during the development of various strategic documents in family planning (Interviews with IPs, MoPH and CO staff and document review).

[73] The Afghanistan national Family Planning Socio Behavior Change Communication Strategic Plan (SBCC) 2019-2023 was developed and endorsed by MoPH.

UNFPA strengthened the capacities of healthcare workers (HCWs) at the public and private health sectors through training on family planning counselling, contraceptive technology, use of contraceptive decision-making tools, and new contraceptive methods. UNFPA contributed to strengthening Public-Private partnership where 50 private hospitals signed agreement with the MoPH to provide free FP services with MoPH is providing the commodities donated by UNFPA, in addition to 128 FP service providers from 118 private clinics in Kunar, Laghman, Samangan, Badakhshan and Kabul being capacity built on LARC and FP counseling and provided with guidelines and protocols for use (Interviews with MoPH and CO staff and SIS). The capacity of 236 healthcare workers was built on the implementation of the Long Acting Reversible Contraceptives (LARC), which included implants and IUCD. The healthcare workers also received implant and IUCD insertion kits, reporting tools and implants for their use in the respective health facilities (Interviews with IPs, CO and MoPH, and document review). Cognisant of the need to ensure concerted efforts in increasing male involvement in the advocacy for the uptake of contraceptives, UNFPA supported training of specific Male HCWs on the modern contraceptive technology to enable them improve the understanding and lead in sensitizing men on the same (Interviews with MoPH, IP and CO and document review) UNFPA developed the Subcutaneous Injectable Contraceptive Depo Provera (SC-DMPA) training package and job aid for Community Healthcare Workers (CHWs). UNFPA facilitated training of Community Healthcare workers' master trainers (ToTs) from different provinces on FP counselling and SC-DMPA who further trained other staff in the provinces, in addition to introducing the SC-DMPA, improving the access of women to injectable contraceptives and the counselling skill of CHWs to provide quality FP services (Interviews with IPs, MoPH and CO staff and document review).

UNFPA equipped health facilities across the country with FP guidelines and job aid materials such as WHO contraceptives medical eligibility wheel 2015 (WHO MEC wheel) and FP Global Handbook. Monitoring reports and interviews with MoPH, IPs and CO staff confirmed these tools enhanced better utilization of the contraceptive methods through facilitated focus on the rights of the users, in addition to giving them options of making decisions of FP choices, something that never used to happen before. In addition, National Technical Assistants were provided to MoPH to strengthen the leadership and stewardship role of MoPH in FP and RHCS. The NTAs technically contributed to the development of strategic documents, guidelines, and improved coordination of the FP-related issues (Interviews with WHO, MoPH and CO staff and document reviews).

Impact of Contraceptives distributed:

- Through the distribution of contraceptives to clients, an estimated total of 441,682 couple-year protection was provided.
- By distributing contraceptives between 2015-2020, an estimated 184,877 unintended pregnancies and an estimated 294 maternal deaths were averted.
- Also, through the distribution of contraceptives during 2015-2020, an estiated 16,468 maternal DALYs and 212,344 total DALY were averted.
- The distributed contraceptives between 2015-2020, an estimated 6,111,773 in direct healthcare spending were averted.

UNFPA's 4th CP contributed to enhanced capacity of MoPH for evidence-based forecasting, quantification, logistics and supply chain management systems through technical and financial support in the development of LMIS. The LMIS, Channel software, for forecasting and monitoring FP commodities was introduced and the RH managers and RH commodities stock managers from different provinces were trained on the same, in addition to training on Reproductive Health Commodity Security (RHCS) to ensure RH commodities were better managed in terms of costing, distribution, stocking, and reporting. (Interviews with CO and MoPH staff and document review). There were however reported conflicts in the utilization of the LMIS, Chanel, as there were also other systems in place by different donors, for example, World Bank system which was running parallel to the Chanel system, with various stakeholders, especially the BPHS and EPHS partners preferring to use the system by World Bank to minimize duplication of reporting (Interviews with IPs, MoPH and CO staff and document review). While there was great support by UNFPA to improve the capacity and systems in the RHCS, there were reported indications of less commitments and utilizations of the gained skills in improving processes due to different donor interests (Interviews CO and IPs staff and document review).

Towards addressing supply of modern contraceptives and improved access to quality of FP services and commodities, the 4th CP supported the provision and distribution of contraceptive commodities to the government health facilities for ease of access and utilization, (Interviews with IPs, CO and MoPH and document review). To further illustrate, UNFPA procured contraceptives for around 10% of the health facilities in the Country that were not supported by other donor agencies and Afghan Family Guidance Association (AFGA). In addition, the contraceptives such as Implant, pills, DMPA, IUD, and condoms were also supplied to private health facilities (Interviews with CO and MoPH staff and Document review). UNFPA together with MoHRA conducted national and provincial level consultations that led to development of the declaration by religious leaders to support FP in Afghanistan. (document review and Interviews MoPH, IPs and CO staff).

Even though UNFPA made considerable efforts in improving the uptake of contraceptives, in addition to strengthening the capacities of the government and other stakeholders on the same, there still existed limiting factors in improving the CPR. Afghanistan is still deeply-rooted with socio-cultural barriers, including myths and misconceptions about FP, inadequate financial resources to implement the existing FP strategies, inadequate supplies in relation to the demand created (unmet needs). Limited government commitment and prioritizing of FP approach is also contributing to the low CPR. Weak government and partners' financial and technical capacities in the targeted location where women and girls are more affected are also contributing factors inhibiting RH service delivery (Interviews MoPH, CO and IPs staff and document review). Insecurity was also a hindrance to conducting training for religious leaders and community elders because in some of the provinces these two groups were the target of anti-government elements. In addition, low interest of private health facilities to send their staff to training because it interrupted their service delivery in their clinics (Interviews with CO, IPs, MoPH).

4.3.1.2 Strengthened Institutional capacity to deliver comprehensive maternal health services to underserved populations

> "In the past women had to travel to the district centre or provincial capital in order to get their antenatal care visits and ultimately delivery, but with the establishment of the FHHs, the pregnant mothers safely deliver without travelling/walking long distances" – ***FGD with Midwives during the CPE.***

Enhanced access to skilled birth attendance in the White[74] areas

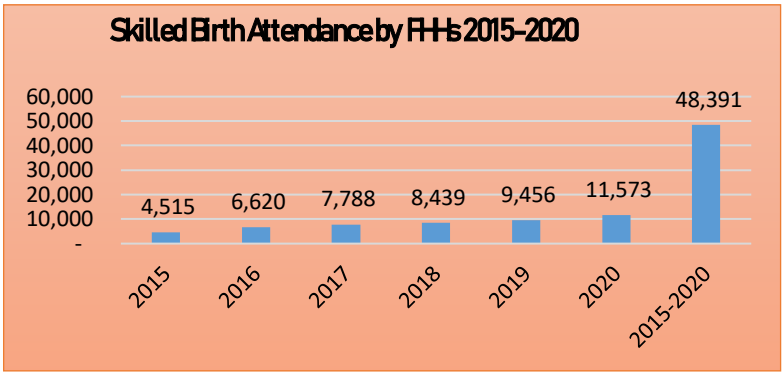
In order to improve access to skilled birth attendance in Afghanistan, UNFPA supported the establishment of family health houses (FHH), strengthening midwifery capacities through education, supporting midwifery association, accreditation and regulation, and 24-hour toll-free midwifery helpline. These contributed immensely to ensuring quality midwifery services and enhancing access to skilled birth attendance, especially in the hard-to-reach areas, including marginalized populations, thereby contributing to reduced maternal mortality rate in the country (Interviews with IPs and CO staff).

Establishment of Family Health Houses: During the 4th CP, UNFPA expanded the establishment of the FHH from 82 facilities at baseline to 146 facilities as at the end of 2019, remarkably enhancing access to essential RMNCH (BEmONC) services by the targeted most vulnerable marginalized and hard-to-reach populations. Notable was the great contribution of the Canadian Government in financing the establishment of FHH facilities in five provinces. UNFPA ensured integration of the facilities with Community Midwifery Education (CME), where –for every FHH established, there is a female community member identified and recruited for training as a community midwife through a 26-month programme[75]. This strategy ensured that the established FHHs had qualified and reliable midwife to provide BEmONC services (Interviews with IPs and CO staff). In addition to the one midwife trained per facility, UNFPA also supported two CHWs (male and female) to sensitize the communities on the available services at the facilities, supplementing the BPHS services. To ensure that the neediest community is selected for establishment of the FHH, UNFPA supported implementation of a detailed community assessment, conducted by a

[74] Underserved communities not covered by the Ministry of Public Health's Essential Package of Hospital Services (EPHS) and the Basic Package of Health Services (BPHS).

[75] Including mandatory 2 months' internship before being deployed into the FHH.

team led by the provincial health director, who are trained by UNFPA on the objectives of the assessment; and the selection of the community midwives is done by Health *Shura* members, ensuring that the right person is selected (Interviews with IPs and CO staff). Further effectiveness was ensured by UNFPA through by supporting 24-hour operation of the FHH, especially



because the midwife is from and within the community. In addition, UNFPA supported training of back-up midwives who would be deployed to support MoPH, with their salaries paid, and would be assigned to work with the FHH midwives, especially where facilities had higher attendances and the provincial health facilities.

The back-up midwives also relieved the FHH midwives whenever they went on leave. UNFPA also strengthened the capacity of the midwives on policy implementation through training them on RH policy for four months (Interviews with IPs and CO staff). In addition to the FHHs, UNFPA also facilitated running health posts (HPs), and activating family health action groups (FHAGs) to serve the populations in the isolated, remote, and hard-to-reach areas in the RHR covered provinces Afghanistan (Interviews with IPs and CO staff).

The services provided at the FHH include ante-natal care, skilled birth attendance, post-natal care and family planning (Interviews with IPs and CO staff). While the FHH provide BEmONC services, they also facilitate referrals for complicated cases to comprehensive emergency obstetric and neonatal care (CEmONC) services in the nearby facilities, most of the times transport is facilitated by the community members. Interviews with MoPH, IPs and CO staff, in addition to the documents reviewed indicated that the utilization of the FHH services was higher[76], given the level of trust and involvement of the community in their establishment, compared to the health sub-centre. The strategy of selection of locations also contributed to higher utilization rates as they were utilized as they were located in areas not covered by BPHS programme. This enhances the service delivery to the most vulnerable and remote communities. During the period, UNFPA and UNICEF piloted integration of EPI services which effectively worked by enhancing access to the services by the marginalized populations (interview with UNICEF, MoPH and CO staff), and also plans to introduce nutrition services at the FHH, consequences which were unintended at the beginning, enhancing comprehensive service delivery at the community level and addressing more needs. It is also based on the huge difference that FHHs are making in increasing access to RMNCH service that UNDP also funded establishment of more facilities in two more provinces (Interviews with CO and UNDP staff). Interviews with IPs and CO, cited inaccessibility of the services, especially referrals during winter as a challenge to access the services. To curb this, the midwives were supported by UNFPA-supported 24-hour-midwifery helpline where two experts – midwife and gynaecologist, are stationed and the midwives could consult freely in case of a complicated case. During normal operations, the helpline provided technical support on queries of midwives in the field, providing information and guidance, with reports indicating 3000 calls per quarter. Interviews sessions with the midwives indicated that the help line was very effective and reliable, especially in cases where they could not refer for advanced support (Interviews with CO, IP staff and Midwives and document reviews). Insecurity in the target areas and long distance with poor infrastructures also affect supervision at the facilities, especially on mentorship of the midwives. Further, service delivery at the FHH were also reported to be hampered by unavailability of FP

> "The UNFPA-supported mentorship programme contributed to improving the role of midwives by role modelling through working with the weak midwives, changing their behaviours, knowledge and attitude and being more professional in delivery of the services" – **Interview Session with AMA during the CPE**

[76] From data accessed, 300,000 (2015); 803,499 (2016); 364,000(2017); and 127,000 (2018)

commodities and methods (Interviews with IPs and FGDs with Midwives). Government authorities were reported to be very supportive and coordinated well with the FHH implementers, where they could, at times supporting with ambulance to facilitate referrals. To ensure sustainability of the FHH, UNFPA initiated integration[77] with the FHHs into the country's health service package, but this has not been able to take place as the concerns have been on the financial commitment, which is yet to be identified (MoPH and CO staff and Annual reports).

***Midwifery Education*:** UNFPA made immense contribution in strengthening the capacities of the country's midwifery service delivery. In addition to supporting the recruitment, training and deployment of the community midwives, UNFPA through the 4th CP financially supported the development and implementation of a two-year bachelor of midwifery degree programme, a bridging programme for the diploma graduates from the midwifery schools, making a total of four years (document review and interviews with MoPH, AMA and CO staff). This was initially done with a private university and the community midwifery education schools, but later supported Kabul Medical University by hiring a consultant who developed a curriculum for the midwifery degree course, and credits determined by the universities offering the course based on their curricula and Association Confederation of Midwives. UNFPA assisted the Ministry of Higher Education to implement the bachelor level Midwifery Programme in full compliance with ICM/WHO standards. Similarly, Kabul Medical University - Midwifery Faculty was supported with Midwifery Modules, Lab Equipment, Technical supplies for Midwifery Bridging and Direct Entry Programmes, with 56 midwives being enrolled into direct entry bachelor degree programme at Kabul Medical University (Annual Report, 2018). These interventions hugely contributed to the human resource capacity development and closing the gap of availability of trained health personnel in the hard-to-reach areas for provision of skilled birth attendance.

Through UNFPA support, AMA is working with the Ministry of Higher Education on how to improve the implementation of the curriculum, including addressing the issue of inadequate professors in midwifery (Interviews with AMA and CO staff). In order to strengthen inadequacy of tutors at the faculty, UNFPA supported enrolment of three MSc Midwifery Degree holders from Iran through South-to-South collaboration as tutors in Afghanistan Midwifery BSc Programmes (Annual Reports and interviews with CO staff). This improvement highly contributes to the advanced access to skills and knowledge on skilled birth attendance in the country.

Midwifery Association Support: UNFPA supported the Afghanistan Midwifery Association as an implementing partner on midwifery mentorship programme and the Afghan midwifery report. The mentorship programme targeted midwives in the hard-to-reach locations, including those in the FHH. This entailed provision of two to three days of assessment of the performance of midwives by AMA-approved technical midwives, and provides support in the areas of weaknesses. This mentorship was very key in capacity building the midwives, and ensured that the services continued at the locations of deployment, saving time for travelling to Kabul or any other location to be trained (Interviews with CO and AMA staff). UNFPA was also instrumental in supporting the AMA to document the State of Midwifery Report for Afghanistan. This entailed collecting data on midwives in the country which contributed to highlighting the situation of midwifery in the country and presented at the International Confederation of Midwives (ICM). This strengthened the delivery of midwifery support in the country through identifications of achievements and areas requiring support, and using that to solicit for more support for the midwives in the country (Interviews with CO and AMA staff).

UNFPA assisted the AMA, MoPH RMNCAH directorate and the department of Nursing and Midwifery to integrate a nationally costed midwifery workforce plan into the national human resource for health plan of MoPH. This helped the midwifery programme to determine the need for midwives at the country level. This plan was developed and approved by AMA board of directors[78] (Interviews with AMA and CO staff). UNFPA also

[77] At the time of the evaluation, UNFPA had hired a consultant to work with MoPH to revise the public health services and PHC to integrate FHH into the new service delivery package

[78] At the time of the CPE, implementation had not begun due to inadequate finances to fund its operations.

supported the AMA to develop a strategic action plan guiding their programming in the country and setting priorities.

Midwifery Accreditation and Regulation Support: During the 4th CP, UNFPA took the lead role in supporting the establishment of Afghanistan Midwifery and Nursing Council, approved by the President of the GoIRA in 2019 for the regulation and accreditation of the work of nurses and midwives (Interviews with AMA and CO staff and document review). UNFPA technically and financially assisted the establishment of AMNC office. In addition, UNFPA funded three technical assistants to develop initial process manuals and technical guidelines for the AMNC operations. The AMNC serves as a governing body to regulate midwifery and nursing profession[79] (mainly practice and education) in Afghanistan, with the government covering for its operational costs (Interviews with CO and AMA staff). This contributes to enhancing quality service delivery by the midwives and nurses through standardization of procedures and implementation of guidelines.

Maternal and Neonatal Death Surveillance and Review

In order to track the causes of maternal and newborn deaths in the hospital settings, UNFPA provided technical and financial support in the revision of Maternal and Neonatal Death Surveillance and Review (MNDSR) guideline and standard operating procedures (SOPs) to the general directorate of Evaluation and Health Information System (EHIS) of MoPH. UNFPA built the capacity of healthcare providers and maternity and midwifery leaders on MNDSR and vital statistics reporting, review and feedback mechanism in different provinces. UNFPA piloted the MNDSR at the provincial levels. The implementation of the MNDSR, for the first time, helped establish the identification, notification, and review of maternal and new-born deaths followed by actions to improve quality of care and prevent future deaths. The MNDSR further contributed to the generation of knowledge and information on the causes of preventable maternal and new-born deaths (Interviews with CO, MoPH and WHO, and Annual reports).

Although the skilled birth attendance was improved through provision of basic maternal healthcare services by the establishment of 146 family health houses for the vulnerable populations and by training midwives for the hard to reach areas, there were still certain challenges that existed in population access to health services. One of the challenges was that there were still big number of people living with inadequate access to health services. The need for establishment of more FHHs was evident from the huge number of people utilizing the services of the already established FHHs. The established FHHs were over-burdened and under-staffed. To clarify this, at the beginning, the awareness of the catchment populations from the existence of FHH was low. As the time passed, the awareness increase, more and more people visited the FHH for seeking healthcare including for childhood illnesses. Most of the FHH midwives were complaining of high number of OPD, understaffing, and drug shortages (FGDs with Midwives, Interviews with CO, IPs and MoPH staff).

Obstetric fistula response and management

The 4th CP also focused on Obstetric Fistula (OF) and Pelvic Floor Disorders (PFD) case identification, treatment, and linkages to social reintegration programmes, in line with international standards. UNFPA concentrated on the institutionalization of routine fistula care, which effectively enabled continuous treatment of the cases identified. UNFPA contributed to policy advocacy, capacity development, knowledge generation and service provision on obstetric fistula. UNFPA supported Malalai Maternity hospital, Herat Provincial and Nangarhar Regional Hospital through OF ward renovation, logistics and supply of equipment, capacity development and training, and provision of financial support to the clients (Interviews with Malalai hospital and CO Staff).

The 4th CP strengthened the health workers' capacity in the three facilities to identify/diagnose fistula cases, enhancing access to the advance healthcare services. UNFPA strengthened capacities of the obstetric fistula surgeons in the facilities to conduct pelvic floor repair operations through hiring of a surgeon who stayed in the country for three months conducting surgeries

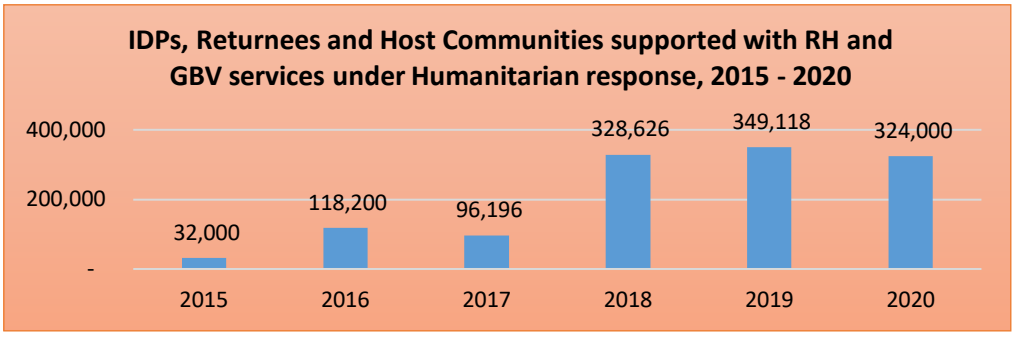
[79] Initially, this was done by a committee which was quite limiting as it was only accrediting and not regulating the work of the nurses and midwives

for the obstetric fistula cases while at the same time training the attached surgeons on OF and PFD, with the surgeons and other healthcare workers gaining practical skills on the same. Through UNFPA partnership, Malalai Maternity hospital was linked with KU for practical purposes in treatment of Obstetric Fistula, which further enhanced the learning processes for the students through practice. UNFPA supported development of short curriculum to integrate OF into the medical university. In addition to Malalai Maternity hospital, UNFPA also supported Herat and Nangarhar Regional Hospitals, where surgeons and nurses were trained on the same, especially through experienced surgeons from Malalai hospital and were able to handle simpler cases of fistula. Two fistula surgical teams from Malalai (2 surgeons, 1 anaesthetist, and 2 nurses), and from regional hospitals of Herat, Balkh, and Nangarhar (1 surgeon, 1 anaesthetist, and 1 nurse each) were trained by the consultant surgeon. UNFPA also contributed to equipping the three health facilities with theatre equipment, drugs, and other medical and non-consumables during the period. UNFPA also supported renovation of theatre and wards. UNFPA also supported the OF survivors and caregivers, for each of the case treated, through provision of accommodation and transportation allowances. UNFPA assisted RMNCAH directorate with National Technical assistant to coordinate National O.F advisory committee meetings for coordinating the OF related issues

4.3.1.3 UNFPA's Contribution to the Afghanistan Humanitarian Response

Interviews conducted with humanitarian stakeholders within the UN, NGOs and Line ministries recognized the key role played by UNFPA during the 4th CP in strengthening RH and GBV services in the humanitarian situation, responding to the major reproductive health needs. These were done through advocacy, policy development, data collection, coordination and service provision, using human rights-based approaches to enhance response. UNFPA actively enhanced coordination of the RH and GBV interagency working groups, strengthened capacities of the national stakeholders and the UN agencies on humanitarian response, conducted outreaches and distributed supplies in the IDP settlements, emergency situation and hard-to-reach areas in the country (Document Review and Interviews with IPs and CO Staff). UNFPA partnered strategically with Afghan Red Crescent Society (ARCS) covering all the 34 provinces of Afghanistan to effectively respond to the humanitarian situation. The programme is designed to provide lifesaving services to the affected populations.

With the partnership between UNFPA and ARCS, and in coordination with health facilities and provincial levels, UNFPA ensured service delivery in all the provinces in the country covering RHR and GBV through prepositioning of the dignity and emergency RH kits in all the six regions (Interviews with CO staff, IP and document review) for ease of access during an emergency, and in case the roads are closed. In addition, UNFPA contributed to the development of the LRP, endorsed and by the Interagency Working Groups, updated and adapted through RNCH directorate (Interviews with WHO, CO and MoPH). UNFPA ensured a continuum of services were delivered from the community to national level through partnerships and coordination with MoPH, including making referrals at the different levels. In coordination with the health facilities in the affected places and provincial levels, UNFPA made sure that the RH supplies were available, and ensured that the staff and supplies are there in the hospitals. The contribution in ensuring effective service delivery during crisis, they would refer, but when the nearest facility was overburdened with case, UNFPA would support the nearest health facility; for example, during the influx of returnees from Pakistan, referrals were made to Ningarhar hospital which was overloaded with cases, and UNFPA supported another hospital in Jalalabad City to reduce



the load in Ningarhar (Interviews with CO and ARCS staff).

The 4th CP technically contributed to building the capacity of the government to strategically respond to the emergency situation in the country. UNFPA supported the Afghanistan National Disaster Management Authority (ANDMA), which coordinates all responses while each ministry makes ministry level plans, through contributing to the development of the MoPH emergency preparedness plan, in addition to allocating funds and resources to the implementation of the emergency components of the National Health Strategy and specifically the RMNCH strategy. In this contribution, UNFPA supported the GoIRA to reflect the RH and GBV needs of women and girls during emergencies in the RMNCAH strategy and contingency plans of MoPH and humanitarian cluster system, ensuring they were considred during response (Interviews with MoPH, IPs and CO staff and Document review).

UNFPA is an instrumental member of the Humanitarian Response Team (HRT) led by OCHA at the national, regional, provincial and central levels cluster, contributing to the conduct of rapid assessments to establish gaps arising during emergency stations in the country (Interviews with WFP, UN Women, RC and MoPH). UNFPA also contributed to the humanitarian response plan (HRP), ensuring that RMNCH and GBV were covered in the HRP and resourced for (WFP, UNICEF, WHO, RC and CO staff). As the lead agency in data, UNFPA supported in data production for the humanitarian response through the use of satellite imagery technology (Interviews with CO, WFP, UN Women, RC and MoPH).

To enhance standardization of humanitarian response, especially service delivery, in Afghanistan, UNFPA supported implementation of Minimal Initial Service Package (MISP) training in the humanitarian context to various humanitarian actors including NGOs and line ministries, in addition to training on psychosocial support. To ensure capacity at the provincial level, UNFPA supported training of master trainers in the DPHS and RH departments who replicated to the Provincial and district levels, prioritizing disaster-prone provinces and districts where possible (Interviews with CO and MoPH). UNFPA also ensured a pool of trainers at the national level and accessible to support.

During the period, UNFPA contributed to the humanitarian response service delivery through distribution of MISP guidelines, dignity kits, and reproductive health supply management guidelines that were adapted to the Afghanistan context. In addition, UNFPA facilitated the capacity building of healthcare workers on emergency obstetric and newborn care (EmONC) enabling service delivery and access to quality service delivery (Interviews with CO and MoPH staff and Annual reports).

UNFPA supported coordination of humanitarian response in the country through leading, financing or participating in the coordination mechanisms. UNFPA had a joint programme with WFP and UNICEF, focusing on food security and nutrition in the humanitarian context while UNFPA provided RH and GBV service to children, pregnant and lactating women, where relevant. In addition, WFP and UNFPA co-chaired the RMNCH in in Emergency working group, where UNFPA facilitated adaptation of MISP guidelines in emergency, in addition to supporting the MoPH in translating and training on it (Interviews with UNICEF, CO and WFP staff). Further, as the co-chairs of the Health Cluster, working with WHO and IOM, UNFPA supported members like MSF and Intersos with RH and emergency kits, enhancing access to services by the affected people. Humanitarian response coordination was however reported to be weak, especially among the UN agencies and key roles were not institutionally recognized, with or without the presence of the agencies (Interviews with MoPH, CO and IPs). A case in point was reported that if UNFPA was not at the provincial coordination meetings, RH components would not be captured in the plans. On the other hand, there reported instances where UNFPA's contribution in the health clusters was overshadowed by WHO, as the Health Cluster lead, limiting visibility (Interviews with WFP, CO and donor staff). Cluster coordination mechanisms were also reported to be weak in some provinces, with the government coordination mechanisms being stronger, and running parallel to the cluster coordination, affecting coordination and consolidated identification of needs in the provinces (Interviews with CO and IPs).

Through financing mobile health teams (MHTs), and in partnership with various IPs, UNFPA en-

hanced access to integrated RH and GBV services by the displaced populations, returnees, most affected during disasters or conflicts, those in hard-to reach areas and the marginalized populations, especially targeting pregnant women and those without access to services. There were a total of 15 mobile health teams supported and deployed by UNFPA during the period, and had their capacities strengthened to effectively apply the skills. UNFPA ensured effective access to maternal services, including skilled birth attendance through deployment of female staff, including midwives to provide RH services in the MHTs (Interviews with IPs and CO staff). The MHT is designed to go to the field for 10 days per month, providing RHR and GBV services, especially in the hard-to-reach areas. In any humanitarian situation, they would establish mobile health facilities in the locations, and then hand over to the nearest health facility, when the situation improves, to continue with service delivery. UNFPA also ensured that team handed over to those trained by MHTs and supported with supplies (Interviews with CO and IPs).

UNFPA supported the during the COVID-19 emergency and during the influx of returnees from Iran and Pakistan. Similarly, during the blast that happened in Zabul province where the provincial hospital was seriously affected, UNFPA provided RH emergency services and supplies. During Helmen Province conflict, UNFPA provided the facilities to NTA of MoPH to ensure that the maternity services were available to the women (Interviews with MoPH and CO staff).

At the onset of COVID-19 pandemic in Afghanistan, UNFPA supported all the maternity health facilities in the country, with PPEs, medical and non-medical kits, enabling continuation of maternity services without disruption during the crisis. It was reported during the interviews that some hospitals were almost closing due to staff concerns of their safety because they did not have PPEs (MoPH, CO and WHO)

During the period of evaluation, UNFPA strengthened the capacities of the government counterparts and CSOs in GBV area of responsibility and RH in the humanitarian setting through training, GBV service quality assurance at the FPC[80], advocacy on GBV, enhancing GBV response for assistance to survivors, and making available technical support in rapid needs assessment across the country (document review and Interviews with IPs, UN agencies and CO staff).

While UNFPA has made huge contributions to the humanitarian response in the country, there were certain challenges that hampered effective response to the emergencies such as inaccuracy of the data and unreliability of data sources including fragmentation in data collection, delay in response due to inaccessibility to the affected areas, inadequate monitoring mechanisms, institutional and financial capacity gaps, inadequacy of technical workforce, weak coordination in the humanitarian country team (HCT) and weak government institutions. For example, WHO, UNFPA, UNICEF do not have uniform set of data, with clear indicators that harmonize data collection (Interviews with CO, UNICEF, WHO and MoPH and document review)

In addition, limited access to the conflict affected population and IDPs due to deteriorating security situation at country level was another frequent obstacle (interviews with CO, IP, MoPH staff and Annual reports). There were also concerns where ARCS asked to be exempted from using UNFPA's logo, which limits visibility and accountability. UNFPA put efforts to overcome this challenge by establishing partnerships with implementing partners who were well accepted in the communities. Inadequate transparency and monitoring of the performance of the operations, in addition to weakness in reporting mechanisms in the HMIS where all partners report that they are achieving all the targets, without over and underachievement (Interviews with CO staff). Similarly, limited availability of qualified female health workers to deliver services in the conflict affected and host communities has been frequently observed. However, UNFPA has adapted various approaches to recruit female staff, such as the provision of transportation facilities in areas where accommodation facilities are not available, recruitment of *Mahram* (husband, brother, father or uncle) to work along with the female staff (Interviews and document reviews).

[80] UNFPA ensured that the FPCs provided dignity kits to the survivors, psychosocial support, legal aid, and functional referral mechanism for services not available at the centres.

Staff turnover after training is also an issue. Weak government institutions leading to lack of M&E tools to capture performance and to have accurate data, and inadequate financial resources, leading to less prioritization of humanitarian response. There is still a need for multi-stakeholder involvement in advocacy, especially for funding the humanitarian crisis (Interviews with CO, UNICEF, WHO and MoPH and document review).

4.3.2 Adolescent and Youth

Summary of Findings: The 4th CP made great contributions through technically and financially supporting the development of the National Youth Strategy and National Youth Policy; increased participation of youth in governance and state-building through the youth parliament activities which also included providing platform for the youth views to be taken during the development of the Youth Policy , enhancing access of youth and adolescents to reproductive health (ARH) services in the country through establishment of the youth-friendly services in youth health corners and youth health line, training of healthcare workers on youth-friendly services enhancing quality of service delivery, providing premarriage counselling, and increasing awareness raising mechanisms. UNFPA also facilitated the review of FLE, but this did not get integrated into the school curriculum due to disjointed coordination between MoPH and MoE. There was also little integration of youth issues in the humanitarian programme.

Introduction of the Component

The 4th country programme was to increase national capacity to conduct evidence-based advocacy for incorporating the rights and needs of adolescents and youth in national laws, policies and programmes, in particular healthy family life education and youth-friendly services.

The component had one outcome indicator and three indicators at the output level as illustrated in Table 4.2. UNFPA supported this component's implementation through technical capacity and systems strengthening to respond youths and adolescents needs and rights, including PWDs.

Achievements of Planned Component Results

As illustrated in the table 4.2 below, UNFPA 4th CP achieved most of its targeted results. The programme succeeded in developing three national strategic documents including National Youth Strategy 2017-2021, National Action Plan to Eliminate Child Marriage (in Partnership with DMoYA) and Child and Adolescent Health Strategy (in partnership with MoPH) as these were developed to meet the needs of the adolescent and youth.

Also the UNFPA programme contribution resulted in establishing a functioning multi-sectoral coordination mechanism "oversight committee on youths" consisting of government sectoral ministries that was chaired by the Second Vice President of the country to oversee the implementation of national youth strategy. Family Life Education materials have been developed in partnership with MoPH but the targeted results to implement school curriculum in number of provinces with integration of FLE materials has not been achieved. Inadequacy of fund to provide adequate support to Ministry of Education was reported to be a main restriction to achieve the results. (Annual reports and interviews with CO, DMoYA and MoPH). The 4th CP also facilitated establishment of health services units that integrate youth-friendly health services in basic package of health services in the country national health care programme, with the number of established youth health corners established surpassing the target to stand at 24, instead of 8 (Documents review and FGDs with beneficiaries).

Table 4.2: M&E Framework for the Adolescent and Youth component of the 4th CP

UNFPA strategic plan outcome: Every adolescent and youth, in particular adolescent girls, is empowered to have access to Reproductive health and reproduction rights, in all contexts.

Indicators	Baseline (2014)	Target	Progress against Targets	Comments
Number of evidence-based policies and programmes, including service delivery packages, that prioritize adolescents and youth	1	3	3	UNFPA supported development of the National Youth Strategy, Youth Policy, and National Action Plan to Eliminate Child Marriage
Output 4: Increased national capacity to conduct evidence-based advocacy for incorporating the rights and needs of adolescents and youth in national laws, policies and programmes, in particular healthy family life education and youth-friendly services				
Existence of a functional multisectoral coordination mechanism on youth that advocates for increased investments in marginalized adolescents and youth, within development and health policies and programmes	No	Yes	Yes	Youth Oversight committee chaired by H.E Second Vice President was developed to push the agenda for adolescent and youth in the country
Number of provinces with healthy family life education programme, aligned with international standards, integrated into the high school curriculum	0	4	0	The FLE curriculum was reviewed but has bottlenecks, being finalized for adoption.
Number of health service delivery points which have integrated youth friendly services into the basic package of health services	0	8	24	UNFPA increased funding for the youth and adolescent-friendly services in the country.

4.3.2.1 Evidence-based advocacy for incorporating the rights and needs of adolescents and youth in national laws, policies and programmes, in particular healthy family life education and youth-friendly services

National Youth Strategy and National Youth Policy Development

UNFPA CP provided technical and financial support to DMoYA and its local and development partners, civil society and youth groups to strengthen capacity for policy and strategy development that could respond youths and adolescent needs in the country. This support of UNFPA enabled DMoYA to jointly work with its national partners including civil society and youth groups and develop and endorse National Youth Strategy 2017-2021. These national strategy and policy documents were instrumental for the country as they enabled policy and programme levels focus on youth issues in the country, enhanced demographic dividend and enabled planning among the stakeholders, including donor agencies on youth activities as explained in the sections that follow (Interviews with CO, DMoYA staff, and Annual Reports). The strategy was well acknowledged and approved by the cabinet. UNFPA continuously supported DMoYA with its key role in IANYD and oversight committee on youths to mobilize resources for the strategy implementation with no perceptible progress (FGDs, KII and Documents review).

The development of the National Youth policy and National Youth Strategy immensely contributed to highlighting the youth needs and enhancing focus on addressing the youth situation in the country (Interviews with DMoYA, MoPH and CO staff and SIS reviews). The youth strategy also contributed to elimination of overlaps among stakeholders, especially among the UN-youth-focused agencies, as it is clear on the areas of focus based on their mandates (Interviews with UN Agencies). It is also used among the donors, like World Bank, to target youth issues in the country based on the target objectives. The strategy covers thematic areas in; health, education, gender, employment, youth ministry for technical role, participation and sports. Government ownership has also been enhanced as it guides their work on what to achieve among the relevant ministries. The MoPH has incorporated youth-friendly health services in the service delivery package as prescribed in the youth strategy, including adolescent health strategy (Interviews with DMoYA, CO and IPs and document review). The implementation of the National Youth Strategy is led by the Second Vice President at the High level oversight committee, with nine ministries involved, and UNFPA being part of it for its technical assistance and inputs (Interviews with DMoYA, CO staff).

The development of the National Youth Strategy has also led to the development and approval of other policies to strengthen youth support in the country. The New Graduate Policy has been approved for implementation targeting increased

employment among the youth through paid internship and contributing to the youth graduates gaining experience. The internship period will be recognized and counted as experience period, enhancing future employments opportunities for the youth in the country, thereby addressing issues of fresh graduates finding it difficult to find jobs due to no job experiences. The Ministry of Labour is charged with the fundraising for the policy to ensure that it is supported and strengthened (Interviews with DMoYA and CO staff and SIS review). Development of the New Framework for Higher Education has also been done because of the National Youth Strategy and approved by the high level committee on youth employment, but is yet to be implemented, consequences that were unintended (Interviews with CO and DMoYA staff). It also led to the extension of the youth health line (discussed in the later sections of the report). While the document has made a notable difference on the youth issues in the country, its implementation is hampered by a number of factors. The involvement of nine ministries in its implementation minimizes effectiveness in decision-making thereby leading to delays. There are also inadequate resources available for the implementation of the strategy. The challenges of insecurity in the target locations, limiting the operationalization of the strategy to respond to nationwide needs of the youth (Interviews with DMoYA, CO and IPs staff).

Another success of UNFPA 4th CP contribution to country national agenda was the financing and technically supporting the development of **National Action Plan to Eliminate Child Marriage (NAP).** UNFPA extended its technical support to DMoYA to facilitate the long process of the NAP development and approval by the Second Vice President office. UNFPA advocated to have the action plan approved so as to address the issues of child marriage in the country. This action plan seeks to contribute to elimination of harmful practices in the community through encouraging stakeholders to consider the root causes and identify areas for improvement in, access to and delivery of, effective and efficient service, ensuring the affected girls enjoy their full potential (Interviews with UNICEF, DMoYA, CO and MoPH). The NAP was not implemented due to inadequacy of funds to finance it, in addition to conflicting perceptions on its implementation, especially in the social and traditional context where the minimum age for marriage is not defined (Interviews with UNICEF, DMoYA, CO and MoPH).

The UNFPA 4th CP elevated the focus on Adolescent Reproductive Health (ARH) by supporting the MoPH to develop National Child and Adolescent Health Strategy (Interviews with MoPH, CO and UNICEF and document review). To ensure a technical approach to the development of the strategy, a technical health working group was established to mainly advocate reproductive health issues within MoPH and ensured adolescent health issues were properly reflected in health policies and strategies (Annual reports). These national health strategies with focus on youth and adolescent reproductive rights were guiding national health programmes of BPHS and EPHS implementation across the country, promoting establishment of and training of healthcare workers on youth-friendly services (Document review and interviews with IPs, MoPH and CO staff). UNFPA also contributed to strengthening the institutional capacities of DMoYA and MoPH through recruitment of NTAs, to facilitate transfer of relevant knowledge and skills, office equipment (including provincial offices) structured training providing equipment, furniture and other necessary facilities, training on leadership, management and report writing; in addition to development of technical guidelines in local languages (Interviews with DMoYA and CO and Annual Reports).

Youth Parliament

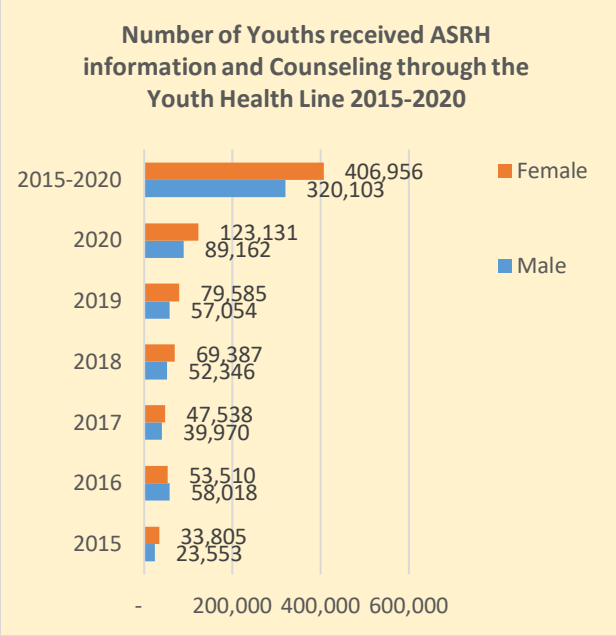
During the 4th CP, UNFPA supported DMoYA in establishment and support of Youth Parliament to advocate for youth issues in the country. Youth parliament, a group of elected volunteers representing youth population from grassroots levels up to the national levels, had offices in 21 out of 34 provinces and conducted monthly meetings at provincial level to discuss issues affecting the youth. Copying the Upper House model, the Youth Parliament had one lady and two men, with more than 35% of female representative. In addition, there was a special quota for disability, four people from the nomadic communities and one slot for Hindu minority. The Youth Parliament provided a platform to the youth to discuss and engage key decision-makers, including the President of Afghanistan to influence decision-making about the youth. Interviews with IPs, DMoYA and

CO staff indicated that the Youth Parliament was successful in enhancing youth participation in decision-making and voicing their concerns (Interviews with UNICEF, DMoYA, CO staff). The Youth Parliament, housed in the Upper House of the National Parliament, enabled youth to engage, debate and prioritize their needs which they presented to the policy-makers to influence them to consider youth-related agenda as a national issue. Notable was their participation in the development of the National Youth Strategy and the National Action Plan to Eliminate Child Marriage, where they contributed through consultation, both at their respective provincial and at youth parliament committee levels. (Interviews with DMoYA, CO and FGDs with Youth beneficiaries[81]).

With the engagement of the youth in the Youth Parliament activities, the government increased the appointment of youthful people into positions of leadership and responsibilities, two of the members were elected into the National Parliament, with one being a Deputy Minister, among others. Given the representation of different cadres of youth population, one of the members, a person living with disability (PWD), who used to represent the PWD in the forum, in addition to acting as a speaker before, was appointed into the Deputy Minister's office due to her active participation in the activities of the Youth forum (Interviews with DMoYA and CO staff). Due to inadequacy of funds, the Youth Parliament support could not continue with its activities (Interviews with DMoYA and CO staff and reports).

Youth-Friendly Services

To increase access to youth-friendly services by the youth in Afghanistan, UNFPA supported the establishment of **youth health corners** and supported the operation of a 24-hour toll-free **youth heath line**. UNFPA, in partnership and consultation with MoPH and implementing partners, established 24 youth health corners (YHCs) in nine provinces of the country, with identified needs, namely Kabul, Kandahar, Nangarhar, Laghman, Kunar, Samangan, Bamyan, Badakhshan and Hirat, with the corners being located in the provincial health facilities (Interviews with CO, IPs, MoPH and document review). In order to ensure effective delivery of the YHC services, UNFPA supported the training of healthcare workers on the youth-friendly service delivery. The training entailed technical skills in handling the youth, ensuring confidentiality of information shared by the youth, enhancing a youth-friendly environment for youths and adolescents especially young girls to seek RH services (Interviews with CO, IPs, and MoPH and FGD with the youth and document review). The YHCs enhanced access to ARH services by the youth in the provinces of implementation, in a very supportive environment (FGDs with Youth, Interviews with CO, MoPH and IP staff) as shown in the chart below.



The Youth Health line, which could be accessed by any youth, on the other hand was established by UNFPA during the 4th CP to support the youth to access vital tele-support through the use of a hotline supported by UNFPA. The sessions with the youth and IPs indicated that the youth were able to get a youth-friendly platform, and that made them comfortable to access information and guidance, in addition to enhanced confidentiality (FGDs with youth beneficiaries and CO). The YHL enabled the youth to access support on a number of issues, including suicide issues, menstruation for girls, sexually transmitted diseases, gender and GBV issues, and for those who needed counselling services were given, in addi-

[81] The development of the Youth policy entailed consultation of more than 500 young women and men in a series of consultation workshops across Afghanistan in Bamiyan, Herat, Jalalabad, Kabul, Kandahar, Kunduz and Mazar-e-Sharif provinces. Accessed from https://afghanistan.unfpa.org/en/news/deputy-ministry-youth-affairs-supports-draft-national-youth-policy-presented-afghan-young

tion to information of the issues of concern, including how to deal with various issues and referrals to YFS (FGDs with youth beneficiaries, KII with CO, MoPH and IPs and document reviews). The intervention has empowered the adolescent and youth on the ARH by getting counselling and information and reportedly averted cases of social misfortunes such as migration, suicide, radicalization and school discontinuation after youth and their parents shared their concerns with YHL counsellors and got action oriented feedback (FGDs, KII with MoPH, CO and IPs). YHL coverage increased from year to year, with a total of 428,433 youth and adolescents were provided counselling on youth reproductive health issues from 2015-19. Disaggregated data of 2018 and 2019 shows that female percentage of clients was 57 and 58 percent respectively (UNFPA annual reports).

UNFPA piloted the implementation of **pre-marriage counselling** to the youth who were planning to get married. To ensure the right skill were in place, Nine MOPH supported through South-to-South cooperation were staff went to Iran on study tour of pre-marriage counselling. In addition, UNFPA build the capacity of the relevant stakeholders on pre-marriage counselling. This was described as a game-changer in the health service provision. In close collaboration with Ministry of Public Health, in existing youth corners supported by UNFPA, Pre Marriage Counselling programme was implemented in five provinces namely; Samangan, Badakshan, Kunar, Laghman and Jalalabad (Interviews with IPs and CO staff and documentary review). UNFPA also supported the development of pre-marriage counselling guidelines, with the Iran versions adapted to the Afghanistan context. WHO, UNICEF and UNFPA worked together to integrate pre-marriage counselling into RMNCH strategy given its success (Interview with WHO, UNICEF and CO).

Strengthening Advocacy for Youth and Adolescents needs

To increase awareness and highlight A&Y agenda in national decision making, UNFPA country program developed and launched Demographic Dividend report for Afghanistan that created and enhanced interest and commitment within government officials on youth issues. The 4th CP conducted mapping of youth organizations and agencies to strengthen and support youth's programs at national and subnational level. UNFPA CO with its leading role continued to chair "Inter-agency Network for Youth Development committee, established at the UNCT level to coordinated youth activities and for resource mobilization (Interviews with CO, UNICEF, RC and and documents review). UNFPA also supported the DMoYA to conduct International Youth days which also contributed to advocating for the rights of the people enhance their participation and involvement in decision making. The advocacy catered across, including those of young girls and women. To strengthen the humanitarian-development nexus, the youth and directly participating in peace and security committees directly, in addition to making the youth voice heard through the Youth Parliament. UNFPA also contributed to the neutralization of extremism through the YHL (Interviews with MoPH, DMoYA and CO).

Family Life Education Program

To increase adolescents and youth awareness on ARH services and information on comprehensive sexuality education (CSE), UNFPA in partnership with the MoPH and MoE designed and conducted assessment to understand different values and attitudes regarding CSE. Using the findings of assessment, the 4th CP supported MoPH health promotion department and child and adolescent department to develop culturally adapted comprehensive family life education (FLE) materials aligned with international standards for integration into the school curriculum (1- 12 grades) in a participatory process with MoPH, MoE and DMoYA (Interviews with UNICEF, CO and MoPH). The revised curriculum materials were officially handed over to MoE (Interview with CO). However, there was reported inadequate coordination between MoPH and MoE to ensure completion of the process (Interviews with MoPH, MoE and CO). While the idea is important for the targeted audience, FLE is considered very sensitive, and the discussion has taken more than six years without success in implementation. UNFPA also included the integration of the FLE into the school curriculum under the Spotlight Initiative project to cover the gaps. (Interview with CO and MoPH and documents review).

PEER Education Networks:

UNFPA CP in partnership with MoPH established Youth PEER education network to increase

awareness of youths and adolescents on ARH, family planning methods, HIV and other social issues. PEER education guideline developed and translated to local languages. A total of 2441 youth's volunteers were trained on PEER education training contents with more than 50% of female participation during the life of CP. UNFPA implemented a joint programme with UNODC, incorporating drug component in the training manual developed (Interviews with CO, IP, MoPH and Annual reports).

Inadequate allocation of funds for youth activities in the CPD inhibited the implementation of key activities, including Youth Parliament which could not continue because of inadequate funds. Inadequate commitment from the government to support and allocate funds to strengthen youth activities in the country is also an issue affecting results. While the programme was purported to be integrated, there was very little to show, especially for inclusion of the A&Y in the rest of the CP components. Inadequate awareness on demographic dividend from government and NGOs and as result they do not realize the importance of investment on youth, which is further effecting the commitment from BPHS implementing partners to supervise the youth health corners and premarriage counselling. There were also reported misconceptions about the youth health line, about the issue of sexuality discussion, and some staff in the platform had been threatened (Interviews with CO, MoPH, UNICEF, DMoYA and document review).

4.3.3 Gender Equality and Women Empowerment

Summary of Findings: UNFPA contributed to strengthening policy, legal, and accountability mechanisms, transformation of attitudes, values, norms that perpetuate GBV, and, child marriage, and provision of services to GBV survivors promoting reproductive rights and women's empowerment. UNFPA also enhanced synergies and leveraging of resources, partnerships for prevention and response to GBV in the country through technically and financially supporting GBV sub-cluster coordination. UNFPA, together with UN women enhanced gender mainstreaming across the UNCT; in addition to supporting GBV Information Management System (GBV IMS) for evidence-based programme and streamlining response. Weak referral pathways, non-existent law in the penal code penalising GBV, absence of legislation, disjointed collaboration hinder response, while at the same time deeply-rooted social and cultural beliefs and practices inhibit GBV response.

Introduction of the Component

The Gender equality and women empowerment (GEWE) component of the 4th Country Programme was designed and implemented to contribute to ensuring advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth, through strengthening capacities of health sector, law-enforcement bodies, community-level duty bearers for the prevention, response and monitoring of gender-based violence and child marriage in targeted provinces. The component had one outcome indicator and three output indicators as illustrated in Table 4.3. UNFPA supported this component's implementation through technical capacity and systems strengthening of GBV prevention and response as well as its strategic and productive role as the national chair of the GBV sub-cluster.

Achievements of Planned Component Results

As shown in Table 4.3 below, the GEWE component surpassed all the targets (Annual Reports 2015 – 2019) showing important contributions by UNFPA the team in strengthening empowerment of women, and girls and elimination of harmful practices in a country that has challenges upholding the rights of women. During the 4th CP, UNFPA strengthened the capacity of the national stakeholders in GBV prevention and response through advocacy, coordination, training and establishment of the family protection centres (FPCs) and the family response units (FRUs). The achievement of a total of 27 FPCs from 6 at baseline, in addition to training of 6,781 healthcare workers facilitated access to services by the GBV survivors in the target locations. Further, strengthening police sector response to GBV through the support of the FRUs, training of 6,170 police and other law enforcement stakeholders laid foundation for strengthened justice system for the GBV response. UNFPA also contributed to the development of policies, guidelines, SOPs and protocols guiding the service delivery in the GBV response and prevention in the country. UNFPA

technically and financially supported the Directorate of Gender and Human Rights at the MoPH to develop Gender and Human Rights Strategic Plan 2019 - 2022, incorporation human rights approach to gender, gender mainstreaming and GBV prevention and response, giving GBV recognition as a health issue (Document reviews and interviews with MoPH, CO and MoWA). While a lot of achievements were made during the 4th CP, the needs are still enormous, including the effects of cultural and social beliefs affection GEWE in the country. Access to justice by the GBV survivors is also still weak and there is non-existent law in the penal code criminalizing GBV, in addition to slow processing of GBV cases leading to survivor withdrawing cases. Weak referral systems also affect service delivery.

Table 4.3: M&E Framework for the* Gender Equality and Women Empowerment *component of the 4th CP

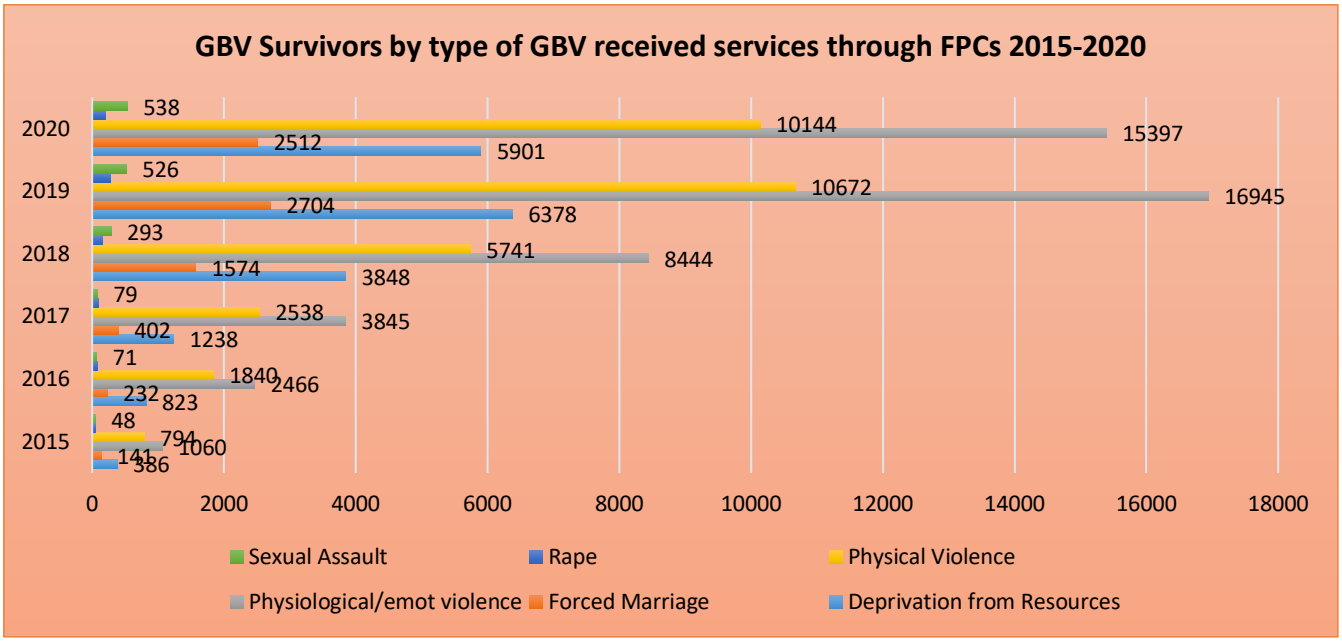
UNFPA strategic plan outcome: Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings				
Indicators	**Baseline[82]**	**Targets**	**Achievement as at CPE**	**Comments**
Proportion of women who have experienced at least one form of violence (physical, sexual or psychological violence or forced marriage) in their lifetime	87.2%	60%	56%	AfDHS 2015
Output 5: Strengthened capacities of health sector, and law-enforcement bodies for the prevention, response and monitoring of gender-based violence and child marriage in targeted provinces				
Number of national policies, guidelines and protocols/ procedures developed and used for the prevention of and response to gender-based violence and child marriage, including targeting vulnerable groups, including internally displaced persons and persons with disabilities	1	3	6	Target surpassed • Multi-sectoral GBV Information Sharing Protocol (ISP) • GBV IMS integration plan; Early and Child Marriages NAP • GBV Sub-Cluster advocacy strategy • GBV psychosocial counselling and FPC operational manual • SBCC Strategy
Number of functional family protection centres established and integrated into the basic package of health services and GBV referral pathways	6	10	27	Target surpassed
Number of health service providers and law enforcement personnel trained to prevent and respond to gender-based violence	280 Health Service providers	1,200 Health Service providers	6,781	Target surpassed
	1,200 law enforcement personnel	4,000 law enforcement personnel	6,170	Target surpassed

4.3.3.1 Strengthening Health Sector Response to GBV

Family Protection Centres

[82] Baseline as at Dec 2014

women and how they can participate in the public



During the 4th CP, UNFPA strengthened access to justice and services for GBV survivors, women and girls through supporting the Ministry of Public Health to manage a total of 27 Family Protection Centres (FPC) established and housed within the provincial or regional health facilities in 22 provinces of Afghanistan. The FPCs are one-stop centres providing comprehensive response and prevention to GBV in Afghanistan. The services provided in these centres include medical support, psychosocial support, legal counselling and referral services. The establishment and expansion of the FPCs enabled GBV survivors to access multi-sectoral services including psychosocial support, legal aid, medical support, dignity kits support and referral services (Interviews with IPs, CO, MoWA and MoPH and Annual report). The facilities are staffed with qualified medical doctors, psychosocial and legal counsellors and a community mobilizer who are at front-line in supporting the GBV survivors to get help. The FPCs' staff are all female and this gives the confidence to the survivors to be able to report and share their cases to the facilities (Interviews with IPs, CO and MoPH). Further, the facilities are strategically positioned at the health facilities which are relatively safe spaces for women to access help without stigma, also seen as places where women can access help without shame; in a society where there is extreme policing on Afghan life, not able to achieve formal economy, and this defines how the women [83]interacts with the public space (Interviews IPs, MoWA and CO).

The FPCs made it easier for the most vulnerable including IDPs and marginalized GBV survivors to access integrated services including ensuring comprehensive support (interviews with CO, MoWA and IPs). The GBV survivors receive a range of medical screenings and treatments at FPC, including treatment for injuries, post-rape examinations, among others, and are given medicine from a list reviewed by the UNFPA medical review committee and revised by MoPH, MoWA and UNFPA (Interview with MoWA, MoPH and CO). On the other hand, the Psychosocial counsellors help GBV survivors manage the mental health impacts incurred from the traumas they have endured. Additionally, GBV survivors can also receive basic legal guidance onsite, where they learn about their rights and the resources available if they chose to pursue the case further for justice. Survivors are offered referrals for further support from the FPCs and are usually linked up with law enforcement units, to pursue the cases further. This however is only done when the survivor consents to pursue the case further (Interviews CO, MoPH and MoWA and FGD with FPC staff). While the FPCs contribute greatly to the GBV response, they are few, and given that it

[83] Source: UNFPA Afghanistan

takes long distance travelling and most women do not have no reliable income source, they would withdraw from pursuing the cases. Poor infrastructure also affects the survivors' access to the services at the FPCs which are mostly in the provincial or regional capitals. Existence of informal justice systems based on traditional or religious *sharia* law in the communities which are discriminatory to women and girls[84], in addition to weak referral systems for GBV response also hinder people reporting cases to the FRC and pursuing them (Interviews with CO, MoWA, FPC staff, IPs and UN Women).

During the period, UNFPA supported development of guidelines on the operation of the FPCs which ensured delivery of comprehensive services. These included development of GBV Psychosocial manual, GBV IMS manual and tools, and Standard operating procedures (SOPs) for health sector response to GBV, where the FPC service providers were trained and guided on how to use them. Monitoring and support supervision reports and interviews with IPs and CO staff indicated that the documents were largely utilized in guiding service delivery mechanisms. In addition, UNFPA strengthened the capacity of the stakeholders including conducting advocacy interventions to increase awareness and utilization of the services at the FPCs as shown in the figure above. Further, UNFPA supported the operations of two FPCs in the humanitarian sector in Herat and Nimroz provinces based at the district levels (Interviews with CO and Annual report).

Women-Friendly Health Spaces

During the period of 4th CP, UNFPA supported the establishment of the Women-friendly safe spaces (WFHS) to provide health services to the women and girls facing stigma in their communities to receive services. The WFHS were instrumental in enhancing referrals to the FPCs. UNFPA supported the operation of these facilities, targeting humanitarian settings especially where conflicts take place necessitating access to health services and other support to women and girls. The facilities have two staff, a psychosocial counsellor and community mobilizer who creates community awareness about the services at the WFHS. The counsellor provides both group and individual counselling to the women and girls at the spaces (Interviews with IPs and Co and document review). Interviews with IPs and CO staff indicated that the WFHS were instrumental in providing women and girls an opportunity to share their experiences among themselves, further enhancing their safe integration and social support, as the community mobilizers in the facilities engage the communities and their leaders on acceptance and integration of the survivors. The facilities offered the women and girls support including trauma healing, psychosocial support and referrals for those requiring help on other services, where UNFPA also facilitated (Interviews with CO and IP Staff). In July 2020, UNFPA piloted provision of vocational skills training at the WFHS to enable the survivors learn craft skills, including tailoring so that they would be able to sell their products, generate income of their own and make them stand in the community or society (Interviews with CO staff and programme reports).

Others: UNFPA also financed and technically supported MoPH to develop a Gender and Human Rights Strategy 2019 – 2022, with participation of a committee comprising UNFPA, WHO, MoWA, Internal Department for policy and MoPH. The strategy has three core objectives covering GBV, human rights and gender mainstreaming, with UNFPA contributing to all of them, but taking the lead on the objective on GBV. Its implementation has greatly contributed to guiding the focus of the Ministry, in addition to eliminating overlap since there is clear focus on the thematic areas (Interview with MoPH and CO staff and Annual report).

4.3.3.2 Strengthening Police and Legal Sector Response to GBV

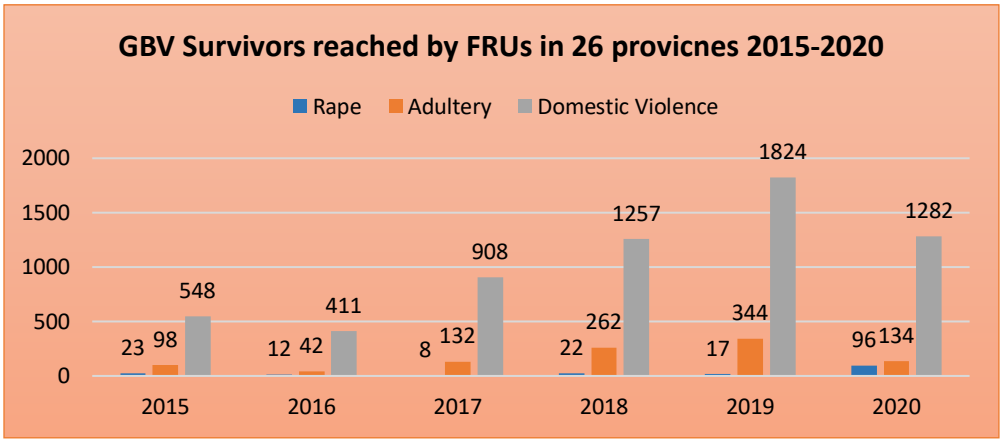
UNFPA contributed to strengthening the police sector response to GBV through supporting the operations of the family response units (FRUs) and integration of GBV response into the police training academy. These are explained in the section that follows.

Family Response Unit:

UNFPA supported the Ministry of Interior (MoI) to operate family response units (FRUs) in 26 prov-

[84] https://www.amnesty.org.uk/womens-rights-afghanistan-history

inces of Afghanistan. This entails building the capacities of the police investigative units to facilitate access to justice by the GBV survivors. FRUs provide an opportunity for the GBV survivors to get support to access justice through profiling their case, conducting investigations and further supporting them during prosecution. The FRUs established by UNFPA and the MoI, through the criminal investigation departments [85](CID) in the country, was to address the lengthy case management procedures which discouraged the survivors from presenting their cases, in addition to the police not having the knowledge on what GBV was and capacity on how they could handle the cases (Interviews with CO and IPs staff). In addition, the FRUs have contributed to strengthening the referral systems, especially in assisting the GBV survivors to access justice, through the legal support, and focusing mainly on the domestic violence cases (Interviews with CO staff). Interviews with IPs, MoWA, MoI, UNDP and RC indicated that the establishment of the FRUs have contributed immensely to facilitating access to justice by the GBV survivors. In order to strengthen the referral mechanism between the FRUs and the FPCs, UNFPA has supported a mentorship programme, where a mentor in each of the 25 provinces, recruited by UNFPA, links the GBV survivors from the FPCs to the FRUs, where they get help for further case prosecution. The mentors have provided a bridge between the FRU and the FPCs at the provincial level and have facilitated the GBV survivors to access the FRUs, though transport facilitation is a limitation (Interviews FPC, CO and MoWA staff). FRUs are however faced with challenges in discharging their services to the GBV survivors. Some of the challenges were inadequate spaces to facilitate confidential handling of the cases, limiting the survivors from expressing themselves, especially in a conservative society. UNFPA endeavours to have female police to handle the cases at the FRUs so as to give confidence to the survivors to share their issues with people they are comfortable with. This is however a challenge in nearly half of police stations in some regions where female police are not available (Interviews with IPs, MoI and CO staff). To further address the case management mechanisms, UNFPA financially and technically facilitated FRU Working Group, Co-Chaired by MoI and facilitated by the UNFPA-recruited mentors, bringing stakeholders together to enhance case management through discussion and ensuring that they are addressed. In addition, the working group also coordinates case follow-ups from the FRU to the AG office for processing (Interviews with MoI, NTA, CO staff).



To strengthen the institutional capacity of the police sector response to GBV in Afghanistan, UNFPA is capacity building the law enforcement bodies, including the police, legal and other key actors. UNFPA facilitated development of a training manual for the police to sensitize and contribute to addressing GBV. The manual, *Police Taking Action on Violence Against Women and Girls,* is integrated into the Police Training Academy, which was not initially intended at the design of the CP, which contributes to the orientation of the new recruits on the importance of addressing GBV cases and prevention. This integration also contributed to a high coverage of GBV and information by the police. In addition, UNFPA technically and financially facilitated the development of the guidelines and SOPs used for the support of the GBV survivors at the FRU (Interviews with MoWA, MoI, CO and UNDP and Document re-

[85] **Source**: UNFPA Afghanistan

views). To ensure continuity of the capacity building, UNFPA supported training of one master trainer in each of the 25 provinces, and these have effectively facilitated the training in the provinces, reaching more officers (Interviews with CO and IPs staff). The interviews indicated that the Master trainers facilitated their training effectively with little contributions from UNFPA. The ownership of the police unit was also confirmed when in some instances the master trainers would train with the police unit financing the training logistics (Interviews with CO staff). In collaboration with UNFPA, UNDP also contributed to training of female police officers to make them available to support the GBV survivors at the FRUs (Interviews with UNDP, CO and MoI).

GBV Information Management System

To generate timely data on GBV cases being referred to the FPCs, a GBV database was set up at the FPCs with the data being captured by the staff at the centre. The GBV database is online, developed and operationalized in the provinces with internet access, and MoPH's directorate of Gender and Human Rights is able to access and monitor it, providing evidence-based response to GBV through data collected from the system, analysed and used to prioritize response based on case prevalence (Interview with MoPH, CO and UN Women). To strengthen GBV response, UNFPA supported MoPH to develop training manual for GBVIMS and amend tools facilitating guidance on information sharing with clear protocols, enhancing confidentiality mechanisms in the data shared, including survivor data protection. The aim of this is to harmonize GBV data in the country, where all stakeholders can contribute in reporting of cases, ensuring confidentiality while at the same time streamlined response, with no duplication of support (Interviews with CO and MoPH staff). While GBV IMS is a good idea to enhance response in the country, a number of stakeholders, especially at the GBV sub-cluster coordination forum stated that it was not being used among the members, with some not even aware of its existence, contrary to the results of the document reviews stating that people have been trained on it since 2015. Another aspect that came up during the interviews was that the GBV data collection in the country is disjointed as the key stakeholders, MoI, MoWA and MoPH were having parallel databases, and can always present issues of duplication of efforts, especially given that cases are also filled anonymous. There is also no data system at MoI and this can compromise the confidentiality involved in the cases reported There were however efforts made by UNDP and UNFPA to harmonize the databases, which had not taken place at the time of the evaluation (Interviews with UNDP, CO and MoI and Document reviews). There were also reported delays in sending data by the focal points due to long distances to the provincial capital, and noted that the database does not allow for sex-disaggregation (Interviews with MoPH, and CO).

GBV Sub-Cluster and multi-sectoral Coordination

UNFPA strengthened coordination and referrals mechanism among GBV key actors through co-chairing of the GBV Sub-Clusters (GBV SC) both at the national and regional level. UNFPA as a co-chair of the GBV SC, technically and financially supported regular meetings with key issues on GBV discussed, informing programme in the various areas of responsibility (Interviews SC members, and CO). These are done at both national and regional levels with the actors with the aim of preventing and responding to GBV in collaboration with various stakeholders, and enabled partners to discuss progress achieved in GBV in the country, with challenges and action points documented for follow ups made in the subsequent meetings (document reviews and Interviews with CO, SC members and UN Women). The coordination mechanisms also enable leveraging resources and partnerships to ensure that areas of gaps were prioritized for response by the partners. Resource allocation was also ensured, maximizing achievement with the available resources and eliminating duplication of effort among the actors addressing GBV (Interviews with CO, SC members and UN Women and document reviews). Through the UNFPA leadership in the GBV sub-cluster, there has been heightened advocacy to address GBV in the humanitarian sector, including allocation of more resources in the humanitarian response plan (HRP) to address the same. Further, it also ensured coordination and mainstreaming GBV in Humanitarian Needs Overview (HNO) and Humanitarian Response Plan (HRP) including narrative, indicators development, province to be targeted, and activity wise

people in need (PiN) analysis, costing and monitoring framework (Annual reports and interview with CO, UNICEF and UN Women). UNFPA also support development and implementation of Contingency Action Plan for GBV sub-cluster, enhancing GBV response in the humanitarian setting. The coordination mechanism among the partners also strengthened advocacy on key issues of priority, in addition to enhancing awareness of GBV as a human rights violation. The sub-cluster coordination has also contributed to strengthening the capacities of the various actors in addition to sharing experiences for an effective prevention and response (Interviews with Cluster members and CO staff). There were however concerns in the GBV SC coordination mechanisms. While the Sub-cluster contributed to strengthening GBV response, it did not have a linkage with the FPCs and FRUs, leading to a disjointed response. Adherence to protocols, especially information sharing was identified as an area of weakness (Interviews with MoWA and CO).

Strengthening Advocacy on Prevention of GBV and Elimination of Harmful Practices

UNFPA contributed to strengthening of the commitment to realize zero violence and intensified advocacy through development of policies and guidelines to support response and prevention of GBV, including harmful practices. During the period, UNFPA in coordination with MoWA and DMoYA and other stakeholders, technically and financially supported the development of the National Action Plan (NAP) on the Elimination of Early and Child Marriage (Annual report and interviews with CO, MoWA and DMoYA) with its implementation affected by inadequacy of funds. With this in mind, UNFPA, together with UN Women, UNICEF and UNDP have secured funding under the Spotlight Initiative project, and should advance the implementation, including advocacy (Interviews with UNICEF, UN Women and CO staff).

At the UN level, UNFPA, UN Women and UNICEF, jointly produced advocacy briefs targeting donors to mobilize funding for GBV under the COVID-19 pandemic, with them securing some funding for response. UN Women led on development of guidance notes on GBV response in the times of COVID-19 (Interviews with CO and IPs). The agencies also reported coordinating commemoration of International Women's day. There is however room to do more advocacy, especially with UNFPA strengthening the GBV IMS strengthening evidence-based response, which can provide real-time data to influence police and resource mobilization, among other uses.

Community Level advocacy

Towards strengthening the health sector response and police sector response to GBV, UNFPA intensified the community level sensitization, conducting community dialogues sessions, involving duty bearers in the 22 provinces targeted. The sessions are held on a monthly basis, with panellists, mostly people of repute like the religious leaders or scholars, teachers, elders, among others to discuss issues of GBV, aimed at preventing GBV, in addition to sensitizing them on the available services at the FPCs and FRUs, including their locations and services offered. In addition, UNFPA supports implementation of sensitization using television and radio spot. During the COVID-19, these were all conducted through TV and radio. UNFPA supported development of the community communications strategy, including a satisfaction survey with the project beneficiaries to get their feedback on the information shared through the community dialogue sessions (Interviews with CO and IPs). These efforts were reported to have contributed to building trust in the services available and the populations were seeking them, in addition to the key stakeholders, like the law enforcement officers learning from the communities and how to improve the services (Interviews with CO and IPs). The community dialogue however needs to reviewed to ensure intensification of information. Service delivery points, the FRU and FPCs also need to be increased, commensurate to the level of information access by the locals (Interviews with CO and IPs).

4.3.4 Population Dynamics

Summary of Findings: UNFPA contributed to strengthening evidence-based planning and development through financially and technically strengthening national capacities in generation, analysis and dissemination of population-based information disaggregated by age, sex, gender, disability among other social indicators. UNFPA strengthened national statistics capacity in survey design, collection, analysis and report writing on RH, adolescents and youth, gender and population dynamics enabling mapping of inequalities and informing interventions during humanitarian crisis. UNFPA supported introduction of use on high resolution satellite imagery to collect population data, enhancing access to information for policy formulation. Utilization of data is a huge gap in Afghanistan and may need to be strengthened in order to realize evidence-based policy planning and formulation.

Introduction of the Component

The 4th CP component of Population dynamics was developed and implemented to strengthen the capacity of the country's national and local stakeholders on data production and management systems; and strengthen advocacy framework for population policy formulation and programming in the country. The component was mainly implemented in support of the National Statistics and Information Authority (NSIA). The component had two outputs, with two and six indicators at outcome output levels respectively and contained in Table 4.4 below.

Achievements of Planned Component Results

The PD component immensely contributed to strengthening of the country's capacity in population data generation, processing and utilization in decision-making. UNFPA was successful in building the capacity of the NSIA technically, financially and through South-South Cooperation to realize the desired result on data. Through the component, NSIA's institutional capacity was strengthened in equipment, GIS, establishment and equipping of data corners at 24 sectoral ministries and government institutions at national levels and in 34 provinces, survey room for quality assurance in data collection, among others. In addition, UNFPA laid foundation for the country in data generation and utilization through supporting Kabul University's Faculty of Economics to review the Statistics and Demographic department curriculum to provide studies in demography. Further, UNFPA supported capacity development of various government ministries on data utilization through advocacy and training. In addition, the 4th CP technically and financially supported NSIA on the use of remote sensing and satellite imagery applying Satellite Imagery and Statistical Modelling technology, one of its kind in the region, to collect population data. This was used to project the population of Afghanistan in addition to the resources available and informed planning (interviews with NSIA, CO and MoEC staff) and annual report). Further, UNFPA supported strengthening of NSIA capacity in designing and implementation of surveys, data analysis and report writing. The achievements of the various targeted results areas were however hampered by huge budget cuts by the major donor, DfID, and the increased cases of insecurity, hindering access to various provinces for SDES. High level advocacy mechanisms on utilization of population data to generate policies was also enhanced during the period culminating into development and approval of various population-based policies, including National Population Policy.

Table 4.4: M&E Framework for the Population Dynamics component of the 4th CP

UNFPA strategic plan outcome: Everyone, everywhere, is counted, and accounted for, in the pursuit of sustainable development				
Indicators	**Baseline[86]**	**Targets**	**Progress as at the CPE**	**Comments**
Number of provinces with sociodemographic data analysed, published and disseminated	4	27	13	Due to funding and security constraints, implementation of the SDES could not continue after mid-2018,

[86] Baseline as at December 2014

				and therefore the indicator could not be measured further
Number of evidence-based national policies, plans and programmes that address population dynamics	3	6		To be reported on at the end of the CP
Output 1: Increased availability of national and local data, disaggregated by sex and age, to formulate, implement and monitor policies and programmes				
Number of provinces that collected sociodemographic economic data	4	34	13	The funding cut by DfID and increased cases of insecurity hindered the achievement of the target.
Number of relevant government staff with competencies in data collection, generation, analysis and dissemination	80	400	306	Due to funding and security constraints, implementation of the SDES could not continue after mid-2018, and therefore the indicator could not me measured further
Number of thematic sub-analysis reports on key population and development issues produced	0	32	27	2015 (9), 2016 (4) and 2018 (14). Budget cuts for the SDES affected achievement of the target.
Output 2: Increased capacity of government counterparts, parliamentarians and academic institutions, in data utilization and advocacy for policy development, planning, and monitoring of programmes on youth, gender equality and reproductive health.				
Number of national and sub-national development plans that used socio-demographic and economic data and information (including utilization of data for disaster preparedness)	4	27	8	2018 (4) and 2019 (4). The target not achieved due to funding cuts for the SDES
Existence of functional Department of Statistics, Demography and Population Studies at KU	No	Yes	Yes	KU Faculty of Economics, Department of Statistics and Population studies strengthened and functional to provide demography and population studies.
Number of key stakeholders from government institutions, parliament, academia, civil society and local authorities trained on population and development issues	100	350	32	Severe funding cuts affected achievement of this indicator.

4.3.4.1 Data availability for policy, plans and programmes

Socio-demographic and Economic Surveys

The 4th UNFPA Country Programme contributed immensely to strengthening the capacity of the country in generation and availability of disaggregated data for policy formulation and programme management. During the period, UNFPA technical and financially supported the implementation of the sociodemographic and economic surveys (SDES) in nine provinces. While the SDES were implemented using sampling techniques, the methodology used, including questionnaire was based on household and census approach, ensuring detailed information were collected to inform decision-making. These surveys brought out the existing gaps and levels of occurrences in various social, demographic and economic indicators, thereby contributing to informing strategies, especially in contributing to addressing the reproductive health rights for all, with a particular focus on women, adolescent and youth at provincial and district levels. With the availability of the data at the provincial levels, the resource allocations were done and needs prioritized based on the SDES data. For example, Interviews indicated that the planning in the provinces with SDES data

were used to prioritize interventions (Interviews with NSIA, CO and MoEC and document reviews). Further, through these SDES conducted, UNFPA contributed to measurement of 11 Sustainable Development Goals (SDG) indicators. UNFPA also supported NSIA to conduct a hybrid census for the entire country which used the SDES dataset as well as other available data sources in areas not covered by the SDES, exhibiting capacity that SDES, supported by the 4th CP, enhanced capacity in the country on generation of data (Interview with CO, NSIA, MoEC).

Also worth noting is that during the SDES implementation, an indicator was included on functional difficulty to include person with disabilities. It is however not clear if there is any particular programme targeting the people with disabilities a part from including their participation in the Youth Parliament; and the guidance of the UN strategy on people with disability in the Disability Inclusion Strategy, with the contribution of UNFPA (Interviews with RC, CO and document reviews). According to a users' satisfaction survey conducted by NSIA in 2018 indicated that 96.7 percent of UN agencies, donors, and international organizations; 81.3 percent of ministries and government departments; and private establishments and NGOS at 62.7 percent had used the SDES data, informing their programming process (Annual Report 2018 and interviews with CO, NSIA and MoEC). To ensure that the SDES implementation processes provided a platform for on-the-job learning for the NSIA staff, UNFPA hired international technical experts and based at the NSIA to guide them on the design of the SDES, while at the same time building their capacities on the same. Interviews with NSIA staff indicated that the transfer of the technical skills in the design, implementation and analysis of data from SDES was effective, and were able to even apply the skills in implementing other surveys with similar magnitude in the country. While UNFPA had planned to ensure that SDES was conducted in 30 provinces during the life of the 4th CP, insecurity and budgetary constraints occasioned by funding cut by the US Government impacted the roll-out of the same in the remaining 21 provinces, and therefore could not be implemented.

To increase availability of data to the various provinces where the SDES were conducted, UNFPA played a key role in facilitating NSIA to conduct in-depth analysis, development and production of thematic reports on key population issues at national, provincial and district levels, enhancing detailed understanding of the areas of need and progress in the social, demographic and economic indicators and integrating population dynamics and part of programme implementation processes. The thematic analysis was based on key socio-economic development indicators, health, fertility, mortality (adult, child and maternal), education, gender, child marriage, adolescent, youth, migration, disability and Household and Family structures (Interviews with NSIA, MoEC, CO and Annual reports). These established reliable knowledge base and supported evidence-based policy development, planning and service delivery at national, provincial and district levels, especially at district levels where no other information source was available at the time providing a detailed level of disaggregation and some of them translated into the local languages for ease of understanding by a wider audience (Interviews with NSIA, MoEC, CO and Annual reports). In order to do this, UNFPA supported a training to NSIA and other planning ministry staff on data cleaning, coding and tabulation, in-depth analysis and reporting to enable them develop the analysis and reporting on the various socio-demographic and economic issues (interviews with NSIA CO and Annual reports). UNFPA and NSIA however need to consistently track utilisation of the acquired knowledge and skills by the beneficiary trainees at national, regional and provincial levels to ensure effectiveness and further support.

Satellite Imagery and Remote Sensing technology in Population Estimation

In order to remedy challenges occasioned by insecurity, hindering access to various parts of the country for large scale household data collection in Afghanistan, UNFPA supported the NSIA to apply innovative mechanisms to support in these gaps. UNFPA technically and financially supported the NSIA on the use of remote sensing and satellite imagery applying Satellite Imagery and

Statistical Modelling technology, one of its kind in the region, to collect population data (interviews with CO, NSIA and RC and document reviews). This was done through South-South Cooperation with the Flowminder Foundation and University of Southampton. This enabled the country estimate, with highest degree of precision, population data disaggregated by age and sex groups for the whole country, augmenting the absence of population and household census (interviews with MoEC, NSIA and CO). The generated data were presented to the government leadership, led by His Excellency, The President; UN country team (UNCT); and diplomatic missions. The government leadership got orientation on the technology and this got their support and buy-in. While the data got the government leadership support, interviews indicated that the data was not accepted in three provinces, which would have interfered with the political processes, given that at the time of the launch, it was an election year, and therefore the whole report was shelved for use in decision-making. This was however not the case among the UNCT and the diplomatic missions, including the World Bank Group and other donors who adopted and used the data for planning and programming (interviews with RC, CO, WFP and Annual Reports). Even though the data from the remote sensing and satellite imagery modelling was not accepted for political reasons, interviews with RC, CO and NSIA confirmed that most of the government sectoral ministries and departments were utilizing the data for planning and progress monitoring purposes. With UNFPA support on use of technology in population level data collection, NSIA is now able to conduct estimation on an annual basis, including supporting decision-making and measurement of the SDG indicators (interviews with NSIA and CO).

UNFPA contributed to the technical enhancement of the internal capacity of the NSIA staff on various data production and management technical skills. These included training of 10 staff on data analysis, 30 staff of geographical information system (GIS) and reporting, data collection design and implementation, and report writing. These ensured that the NSIA conducted other data production without any external support. There was evidence on utilization of the skills in conducting data collection, analysis and use of GIS during the period of evaluation (interviews with CO, NSIA and document review). Since NSIA is the sole institution dealing with data generation in the country for policy formulation and programming, UNFPA also fostered linkage and collaboration with other sectoral ministries of Public Health, Education and Higher Education for data generation through the GIS support to NSIA. The NSIA was able to conduct population estimation, in addition to identification and positioning of health facilities and schools in the country through the help of UNFPA (Interviews with NSIA, CO and MoPH and Annual reports).

During the period of evaluation, UNFPA contributed to strengthening the institutional capacity NSIA by establishing and equipping a computer training and licencing laboratory for GIS. This has laid foundation for the government to facilitate its work, in addition to merging all the GIS departments in all the ministries, which were initially in various locations, to be based at the NSIA facilitating effectiveness and efficiency in management and control through coordination and support activities within NSIA and relevant Government institution (interviews with NSIA and CO). In order to ensure internal capacity on GIS, UNFPA sponsored a staff to train abroad and get the licence. The staff later returned and transferred the skills to the department staff and are effectively utilizing the skills to conduct assessments (interviews with NSIA and CO). Interviews with NSIA and annual reports indicated that the NSIA were able to implement surveys, for the first time, on their own without external technical support using digital platforms. Some of the surveys conducted included Income, expenditure and labour force survey, welfare beneficiary survey, agriculture survey, schools survey on employed teachers including identifying the schools with GPS coordinates and population living near the schools for spatial planning and decision-making targeting the schools. UNFPA also supported the NSIA in the establishment of the survey control room and equipping it with the state-of-the-art technologies including computers and monitors to enable effective and efficient survey management, including real-time field support to the teams (Interviews with NSIA and CO and Annual reports).

4.3.4.2 Capacity development for data use and advocacy on Population Dynamics

Through the 4th CP, UNFPA immensely contributed to strengthening the capacity of the country in utilization of generated data for population advocacy, planning and development. These were done in a number of ways through partnerships, technical assistance, capacity building and financial support. To start with, UNFPA technically and financially supported the Ministry of Economy to develop, the first ever, the National Population Policy (NPP), presented to and endorsed by the government in 2019. The process for development of the policy entailed a lot of consultations, and UNFPA supported dialogues sessions among the stakeholders, ensuring that consensus was built amongst them on the content and its importance. The stakeholders included Members of Parliament, sectoral ministries and the members of the NPP task force. In order to ensure implementation of the NPP, UNFPA also supported the development a costed action plan (interviews with MoEC and CO) and Annual report). To hasten NPP implementation processes, UNFPA supported the MoEc through engaging two NTAs with various roles, including policy analysis, briefing the ministers on population-related cabinet issues, and supporting them on understanding the on the economic indicators in relation to population dynamics (Interview with MoEC and CO).

To further advance advocacy on utilization of data for decision, making, UNFPA supported the government by producing a first of its kind in Afghanistan, demographic dividend report, epitomising potential for a demographic transition contribution to accelerating socio-economic development and the unique opportunity to promote Afghanistan's short and long term development through investing in young people. Out of this, the government has been able to utilize the outcome to enhance targeting of the youth on key aspects of the economy as elaborated on in section 4.3.2. UNFPA conducted orientation session with various policy makers and stakeholders, and interviews with APFPD, CO and MoEC and Annual reports revealed increased investment in the youth activities, targeting spurred development. For example, Government increased focus on strengthening the health system and especially reproductive health and family planning as key to trigger to a demographic transition. UNFPA further supported in producing policy briefs and reports to promote the importance of inclusion of population dynamics in development planning and management. Some of these were; policy briefs: "Harnessing The Demographic Dividend in Afghanistan", and "Strengthen Family Planning in Afghanistan: Opportunity to Reduce maternal mortality"; and reports: National FP Behaviour Change Communication on Strategic Plan; National FP Costed Implementation Plan; Annual Survey on Family Planning Expenditure and Pre-marriage counselling in Youth Health Corners. UNFPA also supported the government in developing Civil Registration and Vital Statistics (CRVS) Strategy, promoting rights-based policy and programme planning[87], in addition to collaboration and interactions among stakeholders. While there is a lot of evidence to show improvement in the utilization of research or evidenced decision-making, there is still a lot to be done in terms of enhancing utilization of policy documents and data generated, including advocacy and capacity building (Interviews with CO, MoEC and NSIA and Annual reports).

Parliamentary Forum on Population and Development

To further enhance advocacy for policy development and implementation, UNFPA in collaboration with the Afghanistan Parliament developed Parliamentary Forum on Population and Development (APFPD), enhancing the role of Parliament in population development and promotion of data utilization; while representing the society in voicing the population issues. The Forum is composed of 34 members, 2 members each drawn from the 17 committees of Parliament. In order to effectively realize the population issues are addressed through Parliament, UNFPA developed orientation manual and conducted orientation

[87] CRVS allows individuals have their existence, identity, and vital events legally recognised, and obtain proof of these legal statuses through valid certificates

sessions to the members, focusing on key population issues including child marriage, youth issues, reproductive health and strengthen the Parliamentary Forum for policy advocacy, budget appropriation, oversight and representation roles. UNFPA also contributed to guiding the operation of the Forum through development of a five-year strategy on population and development issues. The parliamentarians and secretariat staff of the Forum were also trained on integration of population issues in national policies and planning frameworks. The establishment of the Forum facilitated realization of demographic dividend in the country through engagement of key population issues further enhancing advocacy for conducive environment for International Conference on Population, and Development Programme (ICPD) Programme of Action and the Sustainable Development Agenda 2030. UNFPA also established a library for the Forum and equipped it with furniture and computers to enable the members access information for advocacy.

The Forum was strategic for UNFPA in supporting research and addressing population needs through lobbying and raising issues in Parliament in order for laws to be passed. During the period of evaluation, a number of developments took place due to the lobbying of the Forum and orientation on thematic issues, including discussion on Maternal Health, and proposal for the establishment of a council for reduction of Maternal Mortality. These include supporting the establishment of the Family Planning directorate to respond to the low contraceptive rate, identifying the importance of family planning in the country; facilitating the process for the development and endorsement of the National Population Policy; National Action Plan to Eliminate Early and Child Marriage (NAP-ECM); among others. It is worth noting that the Forum facilitates discussions with technical stakeholders, especially ministry heads to discuss the arising population issues to enable clarity and decision-making.

ICPD PoA Commitments by Afghanistan Government

The period of evaluation saw the marking of the 25th Anniversary of ICPD (ICPD@25) held in Nairobi in 2019 to further advance the implementation of the ICPD PoA and accelerate the achievement of the SDGs. To prepare for these celebrations, UNFPA used the opportunity and used its key flagship events, namely; The 2019 State of World Population (SoWP), World Population Day and Youth International Day to promote the agenda of anniversary/Nairobi Summit, with the wider participation of government officials including parliamentarians, donor agencies, UN agencies, civil society and non-governmental organization (NGOs). UNFPA used these celebrations to advocate for the unfinished business of the ICPD, notably emphasising the need of the government to implement the ICPD in line with the SDG, specifically targeting the three transformative results. In addition, UNFPA engaged a circle of journalists to clarify the ICPD PoA, and it importance to the country so that they could also disseminate the information through the various channels of the media. This led to the government committing on the transformative goals by promising to invest in girls, harness demographic dividend and ending GBV in the country. As a follow-up, UNFPA conducted a mapping at the regional level on the commitments to develop a roadmap to ensuring that the commitments were achieved (Interviews with CO and CO Annual report 2019). UNFPA also sponsored a delegation with gender balance and technical expertise to participate in the Nairobi Summit. At the time of the evaluation, UNFPA was working on a roadmap to ensure that the commitments of the Nairobi Summit were implemented.

At inception on the 4th CP, UNFPA conducted orientation sessions on SDG and ICPD beyond 2014 to the government, and advocacy for integration of the same into national development plans. UNFPA also participated and provided technical support to the Ministry of Economy towards the adaptation and nationalization of Sustainable Development Goals (SDGs) in Afghanistan, and workshops on the same, promoting the local focus of sustainable development and use of data for policy-making. UNFPA further contributed to support the SDGs secretariat with human resources, in addition to printing and dissemination of SDGs related documents. Further, UNFPA con-

tributed to the production of data through integration of geospatial data and ground surveys for population mapping estimates disaggregated by age and sex used to support decision making and the measurement of the 98 SDG indicators that require population data (Interviews with CO and NSIA and Annual reports).

Data Corners

UNFPA also contributed to the advocacy in availability and utilization of data in the country, on the premise that this is an area of weakness, through establishment of the Data corners in all the 34 provinces and 24 sectoral ministries and government institutions at the national level, with the data corners being housed at the NSIA provincial offices and some at selected ministries. The support enables accessibility of data and information by data users from all walks of life, especially on the data produced by the NSIA. Some of the data accessible are SDES Data; ALCS Data; Business Establishment Survey data; final 2016-2017 Population data; Export and Import Data 2016-2017; Yearbooks 2016-2017; and all demographic forms for secondary data collection; and all economic forms for secondary data collection, which in turn addressed trust in data for decision-making (Interviews with CO and NSIA, and annual reports). The data corners are equipped with computers, and other equipment, with some equipped with internet, and a collection of publications accessible to the general public and ministries for utilization. UNFPA also monitored the operations of the data corners in the provinces by conducting functionality assessments, informing uptake and utilization of the resources, and necessitating improvements. In addition to the data corners, UNFPA also facilitated a series of workshops and developing capacities of stakeholders on utilization of data at provincial and national levels, and these contributed to enhancing the role of data in evidence-based decision-making (Interviews with NSIA and CO).

Strengthening Institutional Capacity in Statistics and Demography in Afghanistan

In recognition of the dire need for strengthened human resources and technical skills in statistics and demography in Afghanistan, UNFPA partnered with KU in the Faculty of Economics (FoE) to introduce degree programmes in demography, population studies and applied statistics. In order to do this, UNFPA supported the university to conduct capacity needs and demand assessment of the FoE, Department of Statistics studies, results of which led to review and sequencing of course contents, in addition to renaming of the department to Statistics and Population Studies. This paved the way for the development of the FoE on statistics and demography to deliver courses on demography, including major in demography at Bachelor degree level, and a further Masters level in demography (interviews with FoE staff and CO). This contribution makes KU the first of its kind in the framework of higher education in Afghanistan to offer degrees in demography (interviews with FoE staff and CO). The assessment further elevated the importance of demography and statistics, thereby leading to inclusion of statistics courses in 50% of the departments in the university, with the FoE helping in capacity building the university departments. The reviewed content of curricula not only enhance the skills in statistics and demography, but also puts local context in the understanding the dynamics of population-related issues (Interviews with FoE staff and CO).

Recognizing the capacity gaps in the university to provide the training on demography, UNFPA sponsored, through South-South &Triangular Cooperation (SSTC) modality, two lectures for doctor of philosophy (PhD) studies at Mahidol University (Thailand) at the Institute of Population Studies and Research (IPSR) to enable them gain and transfer the skills to the would-be students of demography and UNFPA supporting them financially by catering for the cost of education and stipend for upkeep. Towards attainment of this, the sponsored students spearheaded the drafting, with the support of Mahidol University, a Master's degree curriculum on demography and population studies drafted and awaiting approval by the IPSR, at the time of the evaluation. Further, UNFPA also utilized the modality to enhance partnerships with regional universities to provide support on Statistics and Demography to KU, with UNFPA developing concept notes on the nature

of support and shared with the universities, especially in Iran, Sri-Lankan universities and Mahidol Iniversity in Thailand. UNFPA also strengthened the capacity of KU through sponsoring a FoE member to Tehran University, Iran to undertake a short course on principles and techniques of quality teaching in population studies. This addressed filling in knowledge gaps in the faculty.

UNFPA further strengthened the capacity of the country on developing technical skills on demography and statistics in the country through development of training materials for short courses and conducted a training of trainers (ToTs) to a total of 13 staff (eight from KU, two from MoEc and three from NSIA) on basic and intermediate levels of knowledge and skills on demography, data management, utilization and use of demographic data for decision making/ planning, enhancing long-term capacities for data generation and utilization for development. UNFPA supported in development and translation of Basic Demography Modules, and Trainers manual and trainee's manual into local languages. UNFPA leveraged and facilitated signing and MoU between the university and Tehran and Colombo Universities. Tehran University supported KU training lecturers on advanced skills in population studies and the lecturers replicated that to the classrooms with students, and at the same time trained Policy and planning directors of ministries of health, economy, education statistics office and the Deputy Ministry of Youth. In addition, it sensitized them on the importance of data and appreciating quality and consistency, with courses provided free of charge, while UNFPA provided logistics (Interviews with CO and KU staff). These trainings have further enhanced expertise on demography and are able to articulate, formulate and design policies, with the improved knowledge in the field of study. UNFPA also renovated and equipped one classroom at the university with state-of-the-art equipment, including furniture in readiness for admission of the new students for the course. In addition, UNFPA also supported the department with office equipment. With these efforts UNFPA contributed to increasing the institutional capacity of KU, laying foundation in strengthening the demographic expertise to enhance producing, processing, analysing, disseminating and using population data in Afghanistan to articulate, formulate and design policies relating to statistics and demography.

To further enhance the importance of population dynamics in the country, UNFPA supported NSIA to conduct Afghanistan population projection for the period 2019 to 2030 and its annual impact on key development sectors (health, education, urban, transportation, lodging, and employment) developed with the support of the Asia-Pacific Regional Office (APRO)/HQ and disseminated (document review and interviews with NSIA and CO).

Coordination for Data Sharing and Use

UNFPA plays a critical role in the producing data used in development planning and response in the humanitarian settings within the country. As the Co-Chair of the Data for Development (D4D) committee with the Deputy Director General of NSIA, UNFPA contributes to the harmonization of data production process and advocacy for use of the data generated. For example, within the UNCT, UNFPA facilitates the collection, analysis, dissemination and use of reliable disaggregated data and information for appropriate preparedness and response to emergency situations, informing the humanitarian response planning (HRP) and humanitarian needs overview (HNO) and other development planning (interviews with RC, WFP, and CO). UNFPA is also an active member of and contributes to the donor coordination committee for statistics, established to harmonized data collection and processing, improving the capacity of NSIA, ensuring data consistency and reliability in the country through evidence-based processes (interviews with RC, WFP, and CO).

4.3.5 Level of 4th CP integration of Gender and Human rights-based approaches

Summary of Findings: The 4th CP ensured integration of gender and human rights-based approaches into implementation of its components. The CP had a gender and human rights lens in the delivery of its services. The programme design and implementation is generally founded on gender mainstreaming and rights-based approaches, especially in strengthening policy frameworks and engagement that enhance rights of the marginalized, vulnerable populations to express their rights in addition to non-discriminatory access to services, in addition to eradication of harmful practices.

In alignment with the UNFPA Global Strategic Plans 2014 – 2017 and 2018 - 2020, the design of the 4th CP was grounded on human rights and gender equality principles with the interventions focused on addressing the needs of the most vulnerable and marginalized populations, in addition to addressing dignity and equality of vulnerable women and girls. During implementation, UNFPA endeavoured to ensure as much as possible the framework was considered and applied to enhance gender mainstreaming and human rights approach in the delivery of the programme, especially in targeting people who are vulnerable, marginalized and whose rights are violated against. The implementation also ensured that access to services was non-discriminatory efforts to eliminate harmful practices were in place at all time. Further, UNFPA ensured integration of the gender mainstreaming and human rights approaches into the delivery of the programme through training, conducting advocacy sessions with rights holders and duty bearers, law enforcement agencies, encouraging inclusive policies (Interviews with CO and CO reports). The PD component of the CP also contributed to production of facts and figures disaggregated by sex, age and captured gender and inequality issues (Interviews with CO staff) which are key in identifying gender and human-rights related needs for interventions. The ICPD events culminating into the participation of the authorities in the ICPD Nairobi Summit led to the commitment of the country into the ICPD PoA, which is central to advancing rights-based approaches to services (interviews with CO staff and document review). The implementation and uptake of the services were however influence in a number of ways including societal issues, inadequate resources, access issues, among other limitations.

UNFPA heavily invested in conducting needs assessment to establish the needs and identify those most in need of the services and targeted with services. During the period of review, UNFPA made efforts in identifying and reaching people with disabilities (PWDs) with services. The SDES also had an indicator on functional difficulty to include people with disabilities (PWD), giving targeting of key populations with services delivery. UNFPA, as part of the UNCT, was involved in a joint initiative on development of the UN Disability Inclusion Strategy, targeting people of marginalized groups too. UNFPA also supported, on ad hoc basis, the Ministry of Social Affairs through training on disability related topics. UNFPA also seconded two NTAs to support the Ministry of the same. This contributes to enhancing access to PWD and marginalized people's rights in service delivery and promoting fairness in targeting without leaving those in need behind. Reviews of the reports and interviews with CO, MoPH, UN Women also revealed that there were PWD beneficiaries, especially the PWD representation slot in the Youth Parliament, and in 2019 where 5 women and girls with disabilities subjected to violence accessed the essential services package. A part from these efforts reaching the PWDs, there were no other reported instances where UNFPA specifically targeted PWDs with interventions. It was however reported that disability is still a societal barrier to access services especially in remote and hard-to-reach areas, where most of the UNFPA programmes are, as this is still considered as stigma and people prefer to hide (Interview with CO and CO reports). On the other hand, the GBV health sector response enhanced advocacy for universal access to services to all through community dialogue sessions.

In the implementation of interventions, UNFPA ensured context specific strategies were in place to enhance service access. Given the Afghanistan's conservative context where female mostly feel comfortable talking to fellow female to share their issues, UNFPA endeavoured to ensure that the services were delivered with a gender lens across the three CP service components of RHR, GEWE and Adolescent and Youth. Under the RHR, the programme trained female and male healthcare workers to respond to different roles. For example, UNFPA targeted women for training as midwives, while male healthcare workers were trained on male involvement in FP with female

healthcare worker trained on competency-based Family Planning skills, including Post-Partum IUCD (interviews and document review). Further, UNFPA reached both male and female community opinion leaders with orientation on FP to become advocates of provision of quality services. Services in FP were also provided based on rights as the clients were not coerced to use any method, but they were counselled on the methodologies and they had the rights to choose, including giving consent for the method selected. The WHO Contraceptives medical eligibility wheel and Community Health Workers Decision Making Tool were also used to guide delivery of FP services with healthcare workers trained on how to use them and guide the would-be service seekers. These ensure fulfilment of the rights of women and girls, and families to freely access quality FP and reproductive health services and information (Annual reports and interviews with CO and MoPH). UNFPA immensely contributed to repair, treatment and social reintegration of obstetric fistula survivors promoting restoration of their dignity.

On the other hand, under the Adolescent and Youth, the youth health corners and health lines had both male and female healthcare workers to attend to different needs of the target groups by sex. In addition, the participation in the Youth Parliament as members ensured that fair representation of the provinces was in place with equal representation, in addition to those living with disabilities, minorities and those from members from nomadic, and further ensuring that 33% of girls participated (interviews with DMoYA, CO and youth and document review). In GEWE, the team ensured that the FPCs and FRUs have female staff to handle the cases of the mostly-female experiencing gender-based violations. The case was however limited at the FRUs where finding female police officers to handle cases was a challenge because they were not there (interviews and document review). On the other hand, while interviews indicated existence of male GBV survivors in the IMS, the structure of the referral mechanism did not give them prominence, including the FPCs not having male staff to support them.

UNFPA's work in Afghanistan is tailored to the needs of the country, seeking to reduce the risks at either national or local level, especially in the hard-to-reach areas, among the marginalized communities, those experiencing or recovering from humanitarian crisis. As the data organization, UNFPA contributes to the mapping of demographic disparities, at national and subnational levels, and identifies those in need through collection, analysis, dissemination and use of reliable disaggregated data and information, and either responds or collaborates and advocates with other likeminded agencies for response (interviews with WFP, IPs, RC and CO staff). UNFPA made deliberate efforts through partnerships with stakeholders to reach the hard-to-reach locations, in addition to supporting inclusion and participation of adolescents, youth, IDPs, vulnerable women and girls in access to services, dialogues and education sessions aimed at changing discriminatory gender norms, especially in relation to elimination of child marriage and participation in discourses on implementing their reproductive rights. For example, the implementation of the FHH targets marginalised and hard-to-reach locations which are not targeted by the BPHS and EPHS-supported facilities, enhancing dignity and rights of the affected populations to service provision (interviews with CO, MoPH, IPs and the Midwives and document reviews). Accountability was further enhanced by UNFPA through reporting, programme reviews, monitoring and conducting programme evaluations correcting deviations (interviews with IPs, CO, line ministries and reports)

Implementation of the GEWE component integrates gender and human rights approach in its implementation. In 2018, UNFPA financially and technically supported the MoPH Directorate of Gender to develop Gender and Human Rights Strategy, highlighting the importance of human rights approach to addressing gender-based violence. In addressing the empowerment of women of the country, UNFPA advocates for rights of the female populations and those discriminated against by provision of information, in addition to engaging Islamic scholars especially where the violence is misconstrued by the general public to be Islamic (interviews with CO, MoPH, and MoWA). In addition, the component supports different advocacy mechanisms on the roadmap endorsement for policies and declarations that aim to ensure accountability on human rights of marginalized groups, gender equality, women's reproductive rights issues and gender-based violence

prevention and response in Afghanistan. For example, UNFPA financially and technically supported development of the National Action Plan for Elimination of Early and Child Marriage elevating the rights and dignity focus of the programme. There were also support for training IPs on gender issues, establishment of women and girls'-friendly health spaces, early child marriage awareness (Interviews with IPs and CO staff and Annual reports). In addition, UNFPA supported vulnerable women in the humanitarian settings and GBV survivors with dignity kits (Interviews with IPs and CO staff).

Targeting of the adolescent and youth during the 4th CP with friendly services, involvement of adolescent and youth in programmes that enhance their voices in a context where youth are not involved in governance and state building, supporting development of policies, strategies and platforms that give the young people voice on issues affecting them, enhances rights (Interview with CO, IPs and DMoYA).

Review of programme reports however did not reveal sex and age disaggregated data among the beneficiaries of the programme. The reporting tools (SIS) also did not give provision for disaggregating the data into age, sex or diversity. Further, the reports did not also indicate that IPs received guidance on gender mainstreaming, across the programme apart from the engendered trainings conducted for healthcare workers and social campaigns. While interviews with IPs indicated that they provided sex disaggregated data, gender mainstreaming did not appear to be the underlying objective in the disaggregation.

4.4 Sustainability

EQ5: To what extent has UNFPA been able to support its partners and the beneficiaries (women, adolescents and youth) in developing capacities and establishing mechanisms to ensure ownership and the durability of effects as well as established and maintained different types of partnerships across programme components during CP implementation and exit strategy UNFPA applied to ensure smooth transfer of its support to the national counterparts?

Summary of Findings: UNFPA implemented the 4th CP through the strategic partnership with the government line ministries, in addition to working with community structures while implementing the programme and ensuring ownership of the results and interventions. UNFPA also implemented the CP through partnerships with local NGOs building trust into the community, enhancing ownership of the CP results. UNFPA invested heavily in capacity building of the line ministries, IPs, staff and institutions in the various components, including policy and strategy development, guidelines SOPs and tools development, in addition to enhancing skills transfer and institutional strengthening to enhance delivery of services. Inadequate resource, government commitment, among others affect sustainability.

4.4.1 National Ownership

In the design and implementation of the 4th UNFPA CP promoted national ownership around RHR, Adolescent and youth, GEWE and Population dynamics. The UNFPA CO provided financial and/or technical support to the development of several policies, guidelines and strategies, in close collaboration with the various line ministries and national stakeholders, and most of which were done at their requests and participation (Interviews with line ministries and CO reports). The 4th CP was fully approved and owned by the Government of the Islamic Republic of Afghanistan (GoIRA), and being overseen by the Ministry of Economy. There was evidence of involvement and consultation of the line ministries and national institutions in the development of the CP, including signing of the final CPD, laying grounds for national ownership (Interviews with line ministries, and review of approved CPD).

UNFPA, in the 4th CP successfully nurtured and maintained partnerships with various line ministries, departments and agencies; local CSOs and academic institutions while implementing the CP. The implementation processes also are in alignment with the Afghanistan national priorities, while at the same time ensuring relevance to UNFPA mandate, thereby contributing directly to

the strategies of the government, thereby creating ownership by the government and national stakeholders (Interviews with line ministries and government institutions and document reviews). On the other hand, UNFPA implements the 4th CP through implementing partners, in collaboration with the line ministries, where the line ministries sign the AWPs and MoUs to enable them implement the activities. These ensured that the ministries were part and parcel of the implementation processes of the 4th CP interventions, in addition to the reports being made by the IPs through the ministries' reporting systems (Interviews with IPs, CO and line ministries). Ownership of the CP interventions by the IPs was however mixed as some of them stated that they did not fully contribute to the content of the programme interventions in the AWPs. Some stated that UNFPA gave them the activities, at times including the locations, to implement without them making informed decision (Interviews with IPs and CO).

During the 4th CP, UNFPA financially and technically supported the development of strategic documents such as RMNCAH strategy, Family Planning Costed Implementation Plan, SBCC strategy for Family Planning, and family planning training package targeting various stakeholders, midwifery training curriculum at KU to provide bachelor degree, reproductive health commodity security learning resource package (RHCS-LRP), and orientation package for community gatekeepers, MNDSR guideline and standard operating procedures (SOPs), National Youth Strategy and National Youth Policy, Police training manual on GBV and SOPs, National Population Policy, among others. All these documents were endorsed by the various ministries and institutions involved for further implementation and utilization. However, availability of financial resources has been a challenge towards implementation of these policy documents (Interviews with the line ministries and institutions, CO, UNICEF, WHO and Annual reports).

Implementation of most of the CP interventions were made in the government facilities. For example, the FPCs, FRUs, Youth corners and WFHS are established in the government health and security facilities and implemented by government staff. This shows ownership and should be sustained, especially on the infrastructures established and the staff skills. The performance data from the various 4th CP interventions were reported through the government reporting systems, for example the GBV IMS is integration into the District Health Information System-2 (DHIS-2) and online database is hosted on the MoPH website; showing ownership by the government. There was also evidence of joint supervision and monitoring of the 4th CP interventions in the field (interviews with line ministries, CO, IPs and monitoring reports). During the period of evaluation, UNFPA also financially and technically supported the establishment of FP and Gender units within the MoPH, in addition to the development of the respective unit strategies. These contributions should also be sustained, given their importance in the delivery of the government services (interviews with line ministries and SIS).

There were indications in the integration of the programme interventions into those of the government and resource allocation by the government towards the results of the UNFPA support through the 4th CP. The government is currently supporting the Afghanistan midwifery and nursing council through paying its rent and other operation costs, while its establishment was financially and technically supported by UNFPA. Under the police sector response to GBV, the Ministry of Interior (MoI) has integrated the Police GBV Training Manual - *Police talking action on GBV* into the National Police Academy training curriculum, contributing to the equipping of the new recruits with skills on GBV prevention and response and enhancing sustainability. Further, during the period, there was contribution of the government (MoI) in supporting the provincial master trainers on the police sector GBV response, supplementing UNFPA support, showing clear ownership of the 4th CP interventions (interviews with CO, MoI and document review). Sustainability of results regarding population dynamics is apparent in that government agency, NSIA, fully owns the core activities, such as the SDES, and utilization of the population data from the high resolution satellite imagery by the government institutions to plan, including the Ministry of Finance utilizing the data for allocation of resources to the various ministries and government agencies (Interviews with CO, NSIA and MoEC staff and document review).

Community contribution in the implementation of the 4th CP interventions was also evident during the period in the establishment of the FHH where the community members, led by the Community *Shuras* contributed land for the establishment of the facilities and participated in the identification and recruitment of community women for training of the midwives to operate the FHH. Interviews with MoPH, CO and Midwives and FHH evaluation reports indicate that the community fully owned the FHH and supported on their operations, including contributing to transportation of complicated birth cases to the nearest CEmONC centres using their own resource. The development of the package for religious leaders on the Islamic perspective of FP, was done by an Islamic scholar, and there was ownership of the document by the Islamic leaders (Interviews with MoPH, CO and SIS).

While ownership is clear through custodianship, implementation and utilization of the support products is contributed to by a number of factors. For example, implementation of the statistics and demography studies at the KU is well taken and implemented as designed, with efforts to ensure the benefits are sustained (Interviews with KU staff, CO and document review). Some of the results were however subject to their appreciation by the national stakeholders and still require more efforts to be prioritized, like the National Population Policy and Family Planning Costed Implementation Plan. There were however some that were influenced by capacity issues and coordination challenges, such as the RHCS LMIS, Channel, which is not fully implemented by the MoPH as there is another parallel system by the World Bank for use mostly by the BPHS/EPHS implementing partners, and therefore the intended benefits are not being realized in the country to the expected level (Interviews with IPs, CO and MoPH and Annual reports). Inadequate coordination among government institutions also affected implementation of some of the 4th CP results, like implementation of the reviewed FLE curriculum for primary and secondary education was challenged by inadequate or lack of coordination mechanism between MoPH and MoE. Further, the integration of the FHH into the Afghanistan health service provision systems is facing challenges as there is inadequate financial commitment from the donors to implement it (Interviews with line ministries, IPs and CO and document reviews).

While UNFPA endeavours to address some of the existing gaps, especially on human resources, technical capacity and institutional development, more advocacy and support to the various entities to enhance implementation will be key in ensuring sustainability and full realization of the benefits of the 4th CP results (Interviews with line ministries and government agencies, IPs and CO, UN agencies and CO Reports).

4.4.2 Capacity Building

The 4th UNFPA CP strategically invested in the development of the capacities of its stakeholders with the aim of ensuring continuity of the implementation of the programme results beyond the 4th CP, premised on the assumptions that enhanced capacities of stakeholders in the areas of programme focus should enable them to sustain changes made during CP implementation and the possibility of scaling up the related interventions. UNFPA ensured strengthened capacities in the country skills development, including providing technical assistance through consultancies, South-South collaborations, on-the-job training, facility renovations and equipment support (Interviews with IPs, CO, line ministries and CO reports).

UNFPA enormously contributed to the development of various strategies, action plans, SOPs, guidelines, training modules and policies enhancing capacities of the stakeholders to be able to learn and continue implementation of the supported results. Interviews with MoPH, CO and report reviews confirmed evidence of implementation of the MNDSR guideline and SOPs both at national and provincial levels. The skilled birth attendance capacity in the country also improved through UNFPA's support for continued training of healthcare workers, mentorship and provision of technical support help line for midwives (Interviews with IPs, CO, MoPH, RC, FGDs with Midwives and CO reports). The enhancement of capacities and skills of healthcare workers on FP contraceptive technology and counselling, training of the healthcare workers on RHCS LMIS, training of surgeons on treatment of and training of healthcare workers to identify cases of obstetric fistula, the development of FHH and family planning learning resource packages, obstetric fistula curriculum, and inclusion of obstetric fistula services into the KU curriculum enhance sustainability through the knowledge management

and skills transfer (Interviews with midwives, CO, MoPH, WHO and reports). UNFPA in the 4th CP also supported the linkage of Kabul Medical School to Malalei Maternity Hospital as a teaching hospital, providing orientation to students on fistula builds practical skills and contribute to churning of qualified and experienced graduates (Malalei staff, IPs, CO and MoPH).

Towards strengthening institutionalization of service delivery, UNFPA supported the establishment of Afghanistan Midwifery and Nursing Council (AMNC) which contributes to regulation of midwifery and nursing profession ensuring quality service delivery, in addition to strengthening midwifery associations and standardization of midwifery curriculum according to ICM/WHO standards for Kabul medical University, approved by MoHE; development of a strategic action plan and review of the midwifery act by the AMA will facilitate sustainability of the results (Interviews with MoE, MoPH, CO and FPC staff and CO reports).

UNFPA contributed to strengthening the capacity of the government institutions through improvement of infrastructure to enable effective service delivery. Renovation and equipment of the obstetric fistula wards and theatres in Malalai Maternity hospital, Herat and Nangarhar Regional Hospitals increased the capacity of the facilities to handle obstetric fistula cases (Interviews with CO, WHO, MoPH and Malalai staff and SIS). UNFPA also refurbished the Herat FP regional training centre and Kabul FP training centre supported with training equipment's for facilitation of FP trainings (SIS, MoPH and CO interviews). The 4th CP supported the NSIA through establishing and equipping GIS lab, data control room and data corners within ministries and NSIA, and will continue to facilitate the improvement of data production, processing and utilization in the country. The strengthening of KU's FoE in the Statistics and Demographic studies department through renovating and equipping a classroom for the demographic studies students will remain in the school contributing to its capacity (Interviews with IPs, NSIA, CO and CO reports).

Sustainability was evidenced in the capacities that were built in survey design, data collection and analysis, and report writing. The NSIA staff also confirmed gaining skills from GIS training, in addition to the use of satellite imagery and statistical modelling technology to estimate populations, with evidence of utilization of the skills in conducting surveys in different thematic areas without external help, including making population projections without external support (Interviews with NSIA and CO and reports). The sponsorship of PhD students to lead the provision of demographic studies at master's level, and strengthening the technical capacity of the FoE at the KU in demographic and statistical studies with the training on short courses and review of the curriculum will continue to be and enhance the country's capacity in demography experts. These skills transfer will be utilized to deliver services beyond the 4th CP period (Interviews with CO, KU, MoEC and IPs, and CO reports).

The development of the National Youth Strategy and National Youth policy, integrating all the needs of the adolescent and youth for implementation shows evidence of sustainability, with interviews revealing that they widened the focus of the youth issues in the country. The youth corners' interventions were implemented with existing government staff and within the government facilities staff with no additional cost of implementation, except an incentive of 20 USD (Interviews, FGDs with youth beneficiaries and CO reports). There also exists youth-friendly services manual with 14 modules contextualized to Afghanistan developed by the Adolescent and youth Working Group and approved by the MoPH (Interviews with IPs and CO).

The partnership approach with local organizations also contributes to strengthening their capacities. Interviews with the IPs indicated that they benefited from UNFPA 4th CP training, in addition to application of tools and guidelines, enabling them delivering effectively in their responsibilities, especially in planning, reporting and technical aspects. In addition, the IPs stated strengthened capacities in the various thematic areas covered by UNFPA through the constant capacity building on programmatic, technical and operational areas of focus.

The sustainability gaps during the 4th CP implementation were inadequate policies to address humanitarian-development-peace nexus, inadequate capacity and commitment of the government on implementation of some of the strate-

gies like family planning and NAP-ECM, inadequate financial resource, capacity issues, inadequate political will to tackle early and forced marriage and uptake of FP, and fragility of the implementation context including the socio-economic and cultural changes hindering implementation of some of the CP gains (Interviews with IPs, Line ministries and agencies, FGDs, and reports).

4.5 Efficiency

EQ6: To what extent has the CO made good use of its human, financial, technical and administrative resources, and has used an appropriate combination of tools and approaches to pursue the achievement of 4th CP outcomes promptly?

Summary of Findings: Overall, UNFPA Afghanistan made good use of its human, financial, technical and administrative resources to deliver the programme activities, in addition to strengthening internal controls, ensuring compliance mechanisms. There is however room for improvement especially in terms of staff skills match with the job expectations, enhancing focus on results-based approaches, and enhancing programming in the context of COVID-19.

4.4.1 Human Resources and Operational Efficiency

There is evidence to show that UNFPA Afghanistan made good use of its financial and human resource to achieve programme results. During the period of evaluation, UNFPA had three offices, with two field offices and one head office in Kabul City. The presence of UNFPA in the field enables effective follow-up in the field activities for UNFPA. This also enables UNFPA Afghanistan to conduct its operations effectively, saving time and enhancing quality of supervision. UNFPA's presence in the field is highly valued by the IPs interviewed as it contributes to coordination and oversight for efficient delivery (Interviews with IPs and CO staff and SIS).

UNFPA's staff skill sets were generally effective and appropriate for their roles, especially in the implementation context, facilitating delivery of programme and operational functions (Interviews with government line ministries and agencies, IPs and CO staff). Stakeholders, including IPs interviewed reported that UNFPA Afghanistan staff have the right capacities and were passionate to deliver in their various roles, ensuring delivery of the CP interventions and support in an effective manner. The supportive CO leadership was also identified as a key factor in ensuring that the operations moved, in addition to regional capacity was recognized as a facilitating factor for UNFPA performance in the mandate. All the component leads, except GEWE, were all national staff with relevant qualifications, enabling effective contextual understanding and contributing to facilitating relevant programme interventions (Interviews with CO, IP and UN agency Staff). On the other hand, the CO staff demonstrated a high level of commitment to their work, including display of teamwork among staff within programme thematic area (Interviews with CO, IPs and other stakeholders). Teamwork was however inadequately exhibited within the CO itself, an area that the CO leadership may need to look into and work to ensure integration of the programme and harness the benefits that this comes with (interviews with CO staff). There was however no reported case where there were no deliveries because the CO team never exhibited teamwork.

While UNFPA staff, were reported to be having the right skills sets and delivering in their responsibilities, there were concerns from respondents, especially from government and UN, on the ability of the existing staff capacity to consistently engage at high level technical discussions. The respondents identified inadequacy in participation, especially high level technical engagement involving other counterparts within the UN and other high level stakeholders. As an agency anchored on both upstream and downstream advocacy, it is advisable for the organization to reassess and analyse its strategic positioning, building on niche, identifying opportunities and gaps and coming up with strategies to strengthening the human resource capacity. Another gap ob-

served was in documentation, which the CO recognized was a weakness, and at the time of the evaluation, there was a Communications Specialist, hired on a consultancy basis, and was lauded to be making a difference in the areas of gap (Interviews with CO Staff). Advocacy work require showcasing experiences, documented in the context to present the same to a greater audience, in order to influence perspectives. A permanent role would go a long way in improving the profile of the CO in Afghanistan. The staff capacity in terms of size also needs to be looked into, like the adolescent and youth, and PD components had lean staff, compared to the expected deliverables. The units were however supported with interns or individual consultants to support the teams in achieving their goals (Interviews with CO). Even though UNFPA had two field offices, there was only one Planning, Monitoring and Evaluation Officer at CO level, supported by the Assistant Country Representative, though with the level of coverage of the programme, this can overstretch staff in delivering on their assigned tasks (Interviews with IPs and CO).

On staff capacity development, interviews with CO staff indicated that there is an elaborate plan to strengthen capacities of staff in their career lines and ensure efficient delivery on their areas of responsibility. The staff stated that there are performance reviews conducted on a yearly basis, with clear mentorship plans to develop capacities of staff, and are mostly achieved without much financial investment, especially on the mandatory online trainings in security, procurement, gender, human rights, and Prevention of Sexual exploitation and abuse (PSEA) – Interviews with staff. Staff also reported that there were other technical trainings, especially and mainly for the programme staff, that they were sponsored to attend to enhance their capacities. The national operations staff however reported having limited opportunities for training. Similarly, the staff reported stagnancy in staff grading scales, especially those in operations where it was reported that only one national staff has a professional grading, compared to other UN agencies, while the rest are in general grades, with some having been with UNFPA in the same grades for more than 10 years. Such perceived unfairness can demoralize staff and affect their delivery, in addition to their retentions.

All IPs recognized the technical and operational support they receive from the CO on a regular basis, in addition to capacity building, quick turnaround times regarding authorisation of activities and reprogramming of activities and approval of budgets, enhancing efficiency in management processes. Delays in approval of AWPs for some of the IPs and delays in signing of the MoUs with the government were however identified as weaknesses in the implementation processes, affecting delivery of the programme, especially in the first quarter of the calendar year (Interviews with IPs and CO). The IPs and CO staff however reported that mitigation measures were put in place to ensure that the programme deliverables were made as planned.

UNFPA Afghanistan surpassed the indicative 4th CP budget by nearly six million USD in the first five years[88] of the programme. This was despite the annual budget cut by half due to defunding in 2018 by the US Government (UNDAF MTR, Annual reports and CO interviews). This shows the strength that the CO team was able to show and build relationships for other sources of funding to fill the gaps left by the defunding. The budget utilization for the period of evaluation shows an average of 85.7%, which considerably high, as shown in Table 4.5. To understand this further, the interviews with CO and donors revealed that there were delays in disbursements by the donors which led to underspending on an annual basis. This is an area that UNFPA needs to present to the donors to ensure that the disbursements are done in good time, as this has ripple effects on the delays in signing the AWPs, which in turn affects implementation and thereafter affect results.

[88] The CPD was supposed to end in 2019, but was extended for a further 2 years to align itself to the new One UN document 2018 – 2021. The inactive budget for the period 2015-2019 was USD 82 Million, while the CO was able to mobilize USD 87,982,443 during the same period.

Table 4.5: Budget Utilization rate for the 4th CP Up to September 2020

Year	Budget	Expenditure	Utilization Rate (%)
2015	21,712,046	18,387,281	84.7
2016	25,237,751	23,200,951	91.9
2017	14,794,785	12,518,894	84.6
2018	13,652,236	11,915,323	87.3
2019	12,585,624	12,347,233	98.1
2020	13,479,767	8,548,825	63.4
	101,462,210	**86,918,507**	**85.7**

Source: UNFPA Afghanistan

UNFPA has strong focus on ensuring operational efficiency, by having in place the right internal controls and procedures (Interviews with IPs and CO). There were laid down procedures in going about procurement processes with a focus on ensuring value for money, and takes a very transparent and fair approach with the senior management authorising the requests made, based on available resources and then upload into an online system. The team usually plans at the beginning of the year, for both local and international procurement, and this is usually shared with the programme team, including the timelines for submissions (Interviews with CO and IPs). These ensure efficiency in processes. It was however reported that the programme team has challenges adhering to the procedures and timelines set, leading to some delays or cancellations of procurement requests altogether (Interviews with CO staff). A case is point is in 2020 when the global procurement of contraceptives and RH supplies changed from local purchases to international procurement to ensure quality control. This was shared with the programme, but the response was not immediate as expected, and therefore the items could not be procured. In addition to that, the IPs who had been procuring the contraceptives and RH supplies locally were informed that UNFPA would purchase the items and supply them. As UNFPA could no longer purchase the contraceptives due to the delays, the IPs were told to purchase, which the IPs reported was quite disorienting, in addition to leading to stock-outs. To remedy delays in procurement planning, the CO has devised a method where annual planning starts earlier, and should be completed by November before the following year. Programme staff should also be sensitized to adhere to the procurement policies and procedures so as not to cause reputational damage to UNFPA (Interviews with CO and IPs).

UNFPA has good financial and administrative policies ensuring checks and balances in the internal controls, thereby minimizing risks in the course of programme implementation (Interviews with IPs and CO staff). UNFPA has an online reporting system (both narrative and financial) that is used by the CO and IPs to report on, minimising delays. IPs also confirmed that the systems were user-friendly, as UNFPA frequently conducted training to the respective staff to ensure that they understood and could use the systems.

Interviews with IPs and Strategic partners across all outcome areas widely reported strong and effective technical assistance from the CO team, with evaluation participants reporting that CO programme staff placed high priority on ensuring rapid feedback to their request. The staff were also reported to be flexible to respond to changing requirements and viewed as having an open door policy, which created easy communication and enhanced the partnership. Relationship between the stakeholders in the 4th CP (IPs and CO staff) were noted to be effective, proficient, flexible and cooperative. This facilitated the implementation of the CP in a more consultative manner.

4.4.2 Partnership and Technical Assistance

UNFPA nurtured different partnerships to facilitate implementation of the programme to ensure

efficiency. The partnership approaches used included strategic, especially with the government, within the UN and donors; implementing partners; and community level engagement. All these process facilitated the delivery of the programme in an efficient manner (Interviews with IPs, CO, UN agencies).

Interviews conducted with the IPs and CO Staff revealed how partnering with the government made it easier to implement the CP, contributing to achievements of the programme milestones as it involved consultations and joint planning mechanisms, in addition to ensuring national ownership of the CP interventions. Partnerships with the government also contributed to advancing advocacy mechanisms especially on development, ratification and implementation of various policy documents and guidelines for use in the country (interviews with IPs, Line ministries and CO staff and SIS). UNFPA also played an important role in fostering coordination among government departments facilitating consolidation of resources and coordinated responses, facilitating efficiency in delivery of the interventions. For example, MoWA and MoPH collaborated in the implementation of the health sector response to GBV with clear separation of duties (Interviews with IPs, line ministries and CO staff).

The selection of partners ensured efficient implementation of the programme, evidenced by the high programme implementation rates (IPs and CO Interviews and CO reports). UNFPA selected partners with national coverage, enhancing wider reach, hinged on experience which facilitated the implementation of the project. There were also cases where UNFPA selected partners based on their technical expertise and capacity, based on the IP selection criteria, thereby enhancing programme delivery. For example, IMC and HNTPO were selected based on their experience in health interventions and presence in the target provinces. The selection of ARCS, was also because of its wider coverage and capacity to handle logistics in case of humanitarian crisis, enabling faster response (IPs and CO interviews).

Most of the UNFPA IPs were local organizations with local understanding of the issues, including cultural structures, enhancing local solutions to the various challenges, making it easier for implementation of the programme in terms of community buy-in and ownership (Interviews with UN, CO and IPs staff).

UNFPA utilized the partnership approach to minimize the operation costs through partnering with BPHS/EPHS implementing NGOs, building on their institutional and human resource capacity to support better implementation of the FHH initiative (IPs and CO interviews). In addition to the partnership building with the implementing entities and government, UNFPA also established networks and linkages with the communities for ensuring the RH service delivery to the disadvantaged populations. For example, UNFPA through the establishment of the Family Health Action Groups at the community levels greatly ensured the community ownership of the FHH and implementation of the behaviour change communication for increasing the demand for FP services (Interviews with CO and IPs staff).

Interviews with IPs staff revealed that they had other sources of resources from other donors and therefore the operations costs for implementation of the interventions, especially the operation costs were shared, and therefore ensuring that the delivery of the interventions were co-shared (Interviews with CO and IPs). In most occasions (as reported by the IPs and CO interviews), there existed cost-sharing arrangements, ensuring that UNFPA did not bear all the costs involved in delivering the CP services as the partners engaged had other sources of income from other donors. The partnership arrangement was also vital in minimizing resources utilized to deliver the CP, as UNFPA would have required massive financial resources to implement the country programme directly as a result of its staff remuneration, allowances and operational costs, in addition to the hurdles in the delivery of the programme, especially getting the buy-in of the community to support the programme (Interviews with IP and CO staff).

During the period of evaluation, UNFPA also made available local and international technical assistance through consultants to support delivery of various results in the CP components. IPs, institutions and ministries viewed the support as

effective and used the right approach to enhance their skills thereby contributing to their efficient delivery of the services in their areas of engagement. For example, a consultant surgeon placed at the Malalai Maternity Hospital for three months to train surgeons and other healthcare workers to repair and manage the OF. This was found to be a more efficient way of transferring the skills to the local staff, with wider reach, in addition to practical (Interviews with CO, MoPH and Malalai hospital staff). Further during the implementation of the SDES, UNFPA hired consultants and attached them to the NSIA to support and strengthen their capacities in the implementation of the surveys, enabling more people to learn, which would have otherwise been more expensive, with limited coverage, sending a staff or two for training elsewhere. The same was with the consultant hired to help KU to review the FoE curriculum and train the lecturers on short courses population studies, reaching more people with less (IP and CO interviews).

UNFPA's active role in coordination with partners ensured standardization of delivery of services. Through the RHWG, GBV sub-cluster, IANYD, OF Advisory Committee, MNDSR Committees, among other coordination mechanisms, facilitated leveraging of resources and technical skills, for example, technical guidelines were developed from a multi-stakeholder contributions and disseminated through the coordination platforms facilitating a wider reach (SIS and Interviews with IPs and CO staff). Further, the technical HWG established to mainly advocate for RH issues within MoPH and ensure adolescent health issues were properly reflected in health policies and strategies was successful in its mission, but through concerted efforts (Interviews with CO and IPs). Further, the partnership with the Parliamentary forum on Population and Development facilitated a lot in advocacy mechanisms to elevate the CP activities into national interest, making them get addressed, including passing of bills and policies at Parliament as elaborated in section 4.3. The coordination platforms also served as training grounds for partners, with participants sharing experiences and strengthening synergies (Interviews with partners and CO). There were though concerns of several meeting forums, taskforces and working groups in the government which sometime hampered harmonization and increases transaction cost. A case in point is the high level committee on implementation of the National Youth Policy and National Youth Strategy which involves seven ministries, delayed the implementation of the policy and strategy (SIS and interviews with IPs, CO and RC).

UNFPA was also involved in joint or collaborative mechanisms for consultations among partners of thematic interests, like the UN Agencies in gender and were able to come up with ideas to enhance achievement of results (Interviews with the CO and UN agencies' staff). Further, during COVID-19 pandemic, UNFPA, UNICEF and UN Women designed harmonized advocacy messages on the pandemic in IEC materials, including messages for radio and TV spots (Interviews with CO and UN staff).

The CP enhanced utilization of South-to-South cooperation to support the delivery of the programme interventions in addition to strengthening the capacities of the national institutions and individuals, further achieving results based on pre-identified priority areas of cooperation. During the period, Family Planning National Trainers attended Human Right-based FP training in Indonesia; MoPH staff supported on a study tour in Iran on pre-marriage counselling, leading to development of Pre-marriage counselling guides, ToT training, and implementation of interventions; a midwife from Iran provided support to Midwifery Higher Education policy, conducting midwifery programme assessment, facilitating enrolment of three midwifery tutors from Kabul Medical University on master's programme in the University of Tehran leading to development of Bachelor degree and bridging course curricular for use in Afghanistan. UNFPA also facilitated a consultant to support Kabul Medical University to not only train them on OF, but also trained the national master trainers who eventually conducted training to other healthcare workers who confirmed (interviews with healthcare staff in OF ward, CO Staff).

UNFPA collaborated with regional universities to provide support on Statistics and Demography at

the KU, with Mahidol University in Thailand supporting two PhD students in the same areas of study to enable them go back to Afghanistan and lecture, producing demographers. The University also supported the students in development of a Masters curriculum to ensure it is effectively designed. UNFPA in Afghanistan, in collaboration with Uganda CO also supported KU to develop the Demography short courses in the FoE (Interviews with KU, CO and SIS). The introduction of the spatially disaggregated data for the country using a high-resolution population mapping, which is quicker in delivering the results and cheaper regarding investment was an innovative support by UNFPA to NSIA through South-to-South collaboration with the Flowminder Foundation and the University of Southampton. All these were possible because of the collaborative mechanisms that UNFPA Afghanistan put in place, supporting efficiency in enhancing quality of services in the long-run.

UNFPA also supported the government with paying salary and providing technical support through hiring and deploying national staff for technical assistance (NTA), towards contributing to the government institutional capacity to deliver in their areas of collaboration. Interviews with the respective ministries or government institutions supported recognized the contribution of the NTAs' in providing technical support to facilitate the delivery of the ministries and institutions. There was however no mechanism to capture the contribution of the NTAs (document review and interviews with IPs and CO staff)

4.4.3 Monitoring and Evaluation of the 4th CP

1. The 4th CP monitoring and evaluation (M&E) design is fairly robust, with clear processes and activities embedded in the programme management and delivery. The programme M&E is derived from its results and resources framework (RRF). In addition, UNFPA contributes to the UNDAF M&E plan, and most recently, One-UN Framework 2018 – 2021 (Interviews with IPs, CO, UN agencies, RC and reports). The UNFPA RRF reflects national priorities, UNDAF and UNFPA Strategic Plan outcomes and CP outputs aligned to the UNDAF and One-UN work plans, with a clear resources required for and stakeholders involved in implementation (4th CPD and UNDAF MTR, and interviews with CO).

UNFPA uses the globally designed Strategic Information System (SIS) on planning, monitoring and reporting that is followed by the CO and was reported to be highly efficient, detailed and enables tracking of progress and easy to use, in addition to helping align the 4th CP with the UNFPA Strategic Plan 2018 – 2021 (SIS and interviews with CO staff). UNFPA Afghanistan put in place several M&E processes to assess the performance and provide feedback on the progress of the 4th CP and compliance with the internal systems.

The CO M&E activities were categorised depending on the levels of focus of the actions and the objective. The CP level was conducted by the programme steering committee led by the Deputy Minister of MoEC, done every year, to assess the progress of implementation. On the other hand, there is also a project steering committee reviews overseen by MoPH and the donors on the health sector response to GBV and health sector interventions of the flagship programmes. These were used to review the programme progress, in addition to assessing the arising challenges or contextual dynamics, documenting lessons learnt and suggestions for improvement (Interviews with CO, MoPH and Donors Staff).

At the CP level, the CO conducts monitoring using the AWPs, SIS and the CPD itself, in terms of the plans used, ensuring that the implementation processes are aligned with the guiding documents (Interview with CO and reports). The SIS enables the CO to plan, monitor and report; and is integrated with the regional and headquarter (HQ) offices on the status of the CP by outcome area. The monitoring of the CP is also done through the analysis of the achievements based on the targets in the RRF to inform the implementation progress. Interviews with the CO staff indicated that this process is also used to assess the quality of implementation and deliverables, which were effective in monitoring the performance of the CP based on the indicators targets compared to the baselines. The HQ also conducted quality assurance on the results on policy compliance, using the annual CP work plan on annual basis (Interviews with CO staff). All the processes con-

tributed to enhancing quality assurance and ensuring smooth running and compliance in the implementation processes, eliminating risks and taking corrective measures to assure performance (Interviews with CO staff), hence efficiency. UNFPA conducted quarterly performance reviews based on the AWPs and used grading mechanisms to assess quality of performance of IP. Further, UNFPA held separate quarterly review meetings with the IPs to share experiences in the implementation and documenting progress in the implementation. On the other hand, UNFPA programme teams also made field monitoring visits to the programme areas, together with the IPs, at times jointly with the provincial authorities, with feedback provided to the IPs, Provincial authorities and UNFPA, facilitating understanding and improvement of any challenges that hinder progress of implementation (Interviews with IPs, Ministries and CO).

On monitoring of the resources management mechanisms, UNFPA used FACE forms that the partners used to report on a monthly basis to monitor annual budget monitoring. The CO also used the same platform to monitor the financial expenditures, with action taken in case there were deviations. UNFPA also conducted spot checks for IPs to ensure compliance issues and assure quality (Interviews with IPs and CO staff, and Document reviews). Feedback from the CO staff indicated that the frequency of the spot checks with an IP depended on the risks involved and these were varied to ensure compliance, minimizing the inherent risks about delivery of the CP. During the period of the 4th CP, UNFPA conducted audits on a yearly basis with the IPs and internally (done by the HQ). The IPs reported that the audit findings of the audits were shared with them by UNFPA, and areas of weaknesses addressed through an action plan developed and agreed upon for follow-ups. Reports showed no case of audit qualification among the IPs, showing effectiveness in resources management.

UNFPA used different mechanisms to report and on different frequencies, also contributing to the feedback on the performance of the CP, based on the various achievements reported. Documentary reviews and interviews with IPs and CO staff revealed that the process within the programme were effectively facilitated through the SIS and GPS, and use of FACE forms for financial reporting. The IPs, during interview sessions, reported an effective system of reporting as it allowed them to focus on the planned activities as contained in the AWPs, with specific indicators, guiding effective reporting on a quarterly basis, and based on the targets. Interviews with the CO staff also revealed that the reporting by the IPs was compliant with the UNFPA requirements, guided by the existing systems and tools provided by the CO. The CO ensures that there is effectiveness in capturing evidence-based, quality and standardized reports. The IPs also reported that they were trained on the reporting tools and were conversant with the templates and the results, including indicators areas of the CP. In addition to the SIS and IP reports, the CO staff confirmed reporting to the donors on a varied basis depending on the kind of project being implemented especially for the non-core funding resources. Donors interviewed during the evaluation reported that UNFPA reported on a timely basis, complying with the qualities required. There were however concerns on the level of results reporting. These were also inherent in the SIS reports reviewed, and further confirmed during the interviews of the IPs and most of the CO staff, who could not go beyond the activities implemented to state the results achieved (SIS and interviews with CO). UNFPA may need to strengthen focus on results in the CP implementation as this limits accountability.

At the onset of COVID-19, field monitoring activities, including reviews were affected, with movements from one place to another curtailed. UNFPA utilized remote and third party monitoring (TPM) mechanisms to conduct monitoring activities, in addition to conducting some reviews online. They also used service reports and the contacts at the village levels to monitor the progress of interventions, in addition to verifying the report details, including contacts and the services received as contained in the report.

From document review and interviews with the CO Staff, there is evidence that UNFPA conducted all the M&E activities during the period of focus, save for those that could not be done in 2020 due to COVID-19; however, this was limited to what the M&E capacity could manage. There is evidence that recommendations from the 3rd CP were utilized in the design and implementation of

the 4th CP; like expansion of FHH, evaluation of FHH, using multisectoral approach to GBV prevention and response, among others. During the period, UNFPA conducted an evaluation of the FHH, where recommendations on scale-up into hard-to-reach locations, which was implemented with UNFPA fundraising for more facilities, expanding to 5 more provinces (Interviews with CO staff and document reviews). The 4th CP Mid-Term Review (MTR) was conducted in 2017, and the results were used to redefine the CP ToC, while adapting to the CPD; it also supported in the alignment of the CP to the SP 2018-2021 and SDG and the three transformative goals. The final CPE was conducted according to plan in readiness for contribution to planning for the fifth Country Programme.

While UNFPA had an elaborate mechanism for M&E, the capacity in terms of human resource is limiting and this inhibits frequent field monitoring; and the whole programme is focused on activity level reporting with limited capturing and orientation on results reporting, especially weaknesses in the theory of change to reflect the causal relationships across the logic model. There were weaknesses in the definition of some indicators in the RRF, which did not measure the extent to which the project results were being utilized. On the other hand, there was little to show on the use of disaggregated programme data, some of which were collected during interventions.

4.6 Coordination

EQ7: To what extent has the UNFPA CO contributed to the functioning and consolidation of UN Country Team (UNCT) coordination mechanisms?

Summary of Findings: UNFPA is highly valued counterpart and actively contribute to the functioning of the UNCT coordination mechanism. In addition, UNFPA has joint programming and promoted collaborative approaches in delivering the activities across the thematic areas. There were however mistrust and aspects of competition among the UN agencies, especially in health

The UNFPA CO contributed positively to the UNCT and applied its comparative advantage for the effective and efficient running of the UN coordination mechanisms within the country. UNFPA is an influential key player in the UNCT and has held key responsible positions in various committees, clusters and technical working groups contributing to the country's development and humanitarian agenda. Interviews with various UN agencies staff and the UN Resident Coordinator revealed that UNFPA CO plays a critical role in the functioning of the UNCT, ensuring synergies within the UN mission in Afghanistan and eliminating duplication among the agencies. UNFPA Afghanistan participates regularly in the UNCT meetings and keeps other participants informed of any plans, achievements, and missions (Interviews with CO and UN agencies staff interviewed). All the UN agencies who participated in the CPE indicated the important role UNFPA played in the country's overall development agenda, contributing effectively to improving UNCT coordination mechanisms, particularly strengthening advocacy and technical support in several areas of responsibility (Interviews with CO and UN agencies and reports).

As stated earlier in the relevance section, UNFPA priorities and mandate are well reflected in the One-UN Framework 2018 -2021 with UNFPA contributing to all the thematic pillar both programmatically and financially in the implementation of the framework. The framework includes the UNFPA-related results areas of RHR, adolescent and youth, gender equality and women's empowerment, and populations dynamics. Interviews with various UN agencies indicate that the One-UN Framework has greatly strengthened synergies between agencies in planning, sharing information, co-financing and working together on joint or complementary programmes with contributions of each agency. There were noted challenges in the realization of the commitment to delivering as One-UN, especially in joint or collaborative programmes among the UN agencies,

where lead agencies do not recognize the other cooperating agencies and always want to ensure the visibility of their own agency despite the contribution of the others, and possible issues of competition for funding, although donors increasingly favour joint funding. Progress is reportedly being made to ensure competition is reduced, like it has happened in the Spotlight Initiative programme which has brought together all the gender-related agencies with significant engagement (Interviews with UNICEF, UN Women, UNDP and CO).

UNFPA is an active member of the inter-agency Programme Management Team (PMT), Operation Management Team (OMT) and security management team (SMT). UNFPA participates within the UNCT either as a member, or co-chairs the coordination or thematic areas of the UN framework, based on its comparative advantage. UNFPA co-chairs the Data for Development and Humanitarian (D4DH) Committee, with the Deputy DG of NSIA; Health thematic area of the UN results framework with WHO; Prevention of Sexual Exploitation and Abuse (PSEA); and the youth employment committee, with the Second Vice President. In addition, UNFPA is a member of the High-level Government Oversight Committee for Youth which is also chaired by Second Vice President; where, UNFPA advocates for youth participation, empowerment, and engagement in the country, influencing decisions. UNFPA also chairs the GBV Sub-cluster coordination as part of the AoR, the Inter-Agency Youth Network (Interviews with UNICEF, UN Women, UNDP and CO and reports). Further, UNFPA is a member of the UN Communications group, M&E Working group, and thematic working groups, in addition to heavily represented in the committee for development of the UN Cooperation Framework for Afghanistan mission (Interviews with RC, UNICEF, UN Women and CO and Annual reports). Additionally, UNFPA is a member of the high-level committee, Health Sector Oversight Committee, established by the MoPH and comprises of the MoPH leadership, donors, and UN agencies UNFPA, UNICEF, and WHO, and oversees the performance of health sector and provides strategic guidance to MoPH (Interviews with CO, UNICEF, MoPH and reports). These leadership and contributory possibilities identify UNFPA as a very active member of the UNCT and contributed to its functioning through working with the various partners across the pillars (Interviews with UNICEF, RC and UNDP and SIS).

UNFPA also implemented joint programmes or collaborated with various UN agencies to deliver in various areas of responsibilities. In the humanitarian sector, UNFPA had a joint programme with World Food Programme (WFP) and UNICEF, with both UNICEF and WFP focusing on nutrition components while UNFPA focuses on the RMNCH aspects. In addition, UNFPA co-chairs the RMNCH in Emergency Working Group with WFP (interviews with CO, UNICEF and WFP staff). In 2019, UNFPA, UNDP, UN Women and UNICEF got into a joint programme, Spotlight Initiative, funded by the European Union to combat GBV in Afghanistan. The programme brought out the various strengths among the four UN agencies involved, ensuring that the coordination, eliminating programme conflicts and overlaps, where clear responsibilities are specified in the five core areas of policy, capacity of partners on GBV and child protection, prevention strategy, Service delivery and data generation (Interviews with UNICEF, UN Women, UNDP and CO).

UNFPA also had a joint programme with the United Nations Office on Drugs and Crime (UNODC) in a peer education programme targeting the youth and included drug components in the training manual, with the proposal development process led by UNFPA (Interviews with CO and SIS). UNFPA also took lead in collaboration with UNHCR, UNICEF, WHO and UNDP for developing a joint programme for youth, rationalised on the significant youth population in Afghanistan as well as ready political will to focus on results for youth (Interview with UNDP, UNICEF, CO and Annual Reports). Further, UNFPA as the lead agency for youth programming, and working with other UN agencies, supported the development of several youths related initiative in Afghanistan, e.g., 'National Youth Policy', 'National Youth Strategy', 'Adolescents Health Strategy' and 'National Action Plan for Eliminating Early and Child Marriage'. In addition, UNFPA was a member of a Joint United Nations Programme of Support on Adolescents and Youth (JUPSAY) that brings to-

gether nine United Nations agencies to work collaboratively on youth issues (Interviews with RC, CO, UNICEF, UN Women, UNDP and reports).

In terms of coordination, UNFPA collaborated with IOM and WHO on the delivery of health outcomes in the humanitarian settings. On the other hand, UNDP collaborated with UNFPA in the implementation of the FHH by funding establishment of more FHH facilities in Baghlan and Paktika provinces, in coordination with MoPH through the FHH working group, where UNFPA is also involved in. UNFPA supported by sharing the FHH implementation manual and tools and recommendation for the design of FHH (Interviews with CO and UNDP staff). Further, UNFPA is coordinating with UNDP to unify collection of data under the MoI by finding resources to develop a unified data collection system (Document reviews and Interviews with CO and UNDP staff). On the same note, UNFPA and UNICEF recently collaborated in the integration of the EPI and other child services, on a pilot basis in 15 facilities, into the established FHH facilities (Interviews with UNICEF and CO staff).

In the development of policies and guidelines, UNFPA, UNDP, WHO and UNICEF supported the MoPH in the development of health policy enhancing synergies among the agencies. In addition, WHO collaborated with UNFPA virtually in all the thematic areas of the 4th CP, including in the implementation of the FHH, youth programme, emergency response, population dynamics in support of NSIA, COVID-19 response, GBV, and Policy support in different areas especially in RH including family planning (Interviews with WHO and CO).

UNFPA contributed to strengthening coordination for data sharing and data use among the UN Agencies through the D4DH, GBV Sub-Cluster, and UN Youth Interagency Network meetings (Annul Reports). There is evidence of various UN agencies requesting for data from the SDES technically and financially supported by UNFPA; for example, during the period, UNFPA supported UNICEF with district and village level data on various indicators in the areas targeted, UNHABITAT supported on Herat GIS data, UNOPS on Samangan and Balkh SDES data, among other support to the UN agencies on data, including World Bank using the SDES data for poverty mapping (Interviews with CO, UNICEF, RC, UN Women and document review). In addition, UNFPA contributed to the data used for the humanitarian response planning (HRP) and establishing the needs overview (HNO) by the UN agencies. In addition, UNFPA was part of the joint needs assessment by the UN agencies whenever there was humanitarian crisis in the country. UNFPA was also reported to be taking a lead and active HCT, especially with the leadership in GBV focus within the UNCT, in addition to reporting to the UNCT (Interviews with CO, RC, WFP, UNICEF, and reports).

Under GBV response, UNDP contributed to the inadequacy of female police officers to address the arising GBV cases at the family response units by collaborating in sending female police officers to be trained in Turkey, with UNFPA contributing to development of SOPs. Further, UNDP and UN Women also contributed to the advocacy and policy dialogue on the police sector response to GBV, training police and collaborating in strengthening the referral mechanisms in the country (Interviews with CO, UNDP, UN Women staff and document review). There is also evidence of UNFPA and UNDP conducting joint missions to the police departments, to advocate for more legal support to the GBV survivors at the police unit. In addition, UN Women also contributed to the development of guiding notes on the FPCs, based on the family guiding centres and conducted refresher training on the same, harmonizing the understanding on the operations of the facilities (Annual Reports). UN Women and UNFPA collaborated in the production of three radio spots on Men and women participation in decision-making, where UNFPA supported one while UN Women contributed the rest (Interviews with UN Women and CO). These all show the utilization of comparative strengths and building of synergies among the UN agencies.

In the development and review of the FLE curriculum, UNFPA collaborated with UNESCO, which also reviewed the primary curriculum together with the MoE. This collaboration gives assurance of inclusion of the stalled integration of the FLE into the school curriculum due to lack of coordination between MoPH and MoE.

UNFPA also contributed to the joint advocacy with UNICEF and UN Women on COVID-19 pandemic, developing various advocacy briefs to the donors to support GBV response in the country amid the pandemic. UN Women also contributed in developing of the guiding notes gender issues so as not to lose sight in the times of COVID-19. UNFPA and other UN agencies also contributed to joint functions like the international days of the girls with UNICEF leading in the advocacy for the girls' rights. There is however potential of doing more, especially with UNFPA's contribution data in advocacy to influence policy and funds allocation.

While UNFPA was active in the areas of responsibility in the roles that they led in, UN coordination mechanisms among the UN agencies at the region was also reported not to be effective due to inadequate support for one another. In addition, the youth inter-agency coordination committee was also reported to be inactive as priority was given to youth employment committee, led by the 2nd Vice President. The committee has through since been abolished, giving the opportunity for strengthening the coordination of youth issues. (Interviews with UN agencies' and CO staff).

4.7 Added Value

EQ8: What is the main UNFPA added value in the country context as perceived by national stakeholders?

Summary of Findings: UNFPA is perceived as a strong stakeholder in its areas of responsibility, providing unique services and commitment to work in the field of reproductive health, using a rights-based approaches. UNFPA strengthened the country's capacity in the generation of data for decision-making, provision of youth and adolescent services, strengthening GBV prevention and response and increasing access to RH services in the county. UNFPA also contributed uniquely in the humanitarian response.

UNFPA Afghanistan is an important contributor to the development and humanitarian response in the country. According to the interviews with the national and UN stakeholders during the CPE, UNFPA is perceived as a strong stakeholder in its areas of responsibility, providing unique services and commitment to work in the field of reproductive health, using a rights approach. Within the UNCT, UNFPA is uniquely mandated in the areas of RHR and population dynamics, contributing immensely to the delivery of the priority areas for the UN mission in Afghanistan (interviews with the IP, CO and UN agencies staff), therefore UNFPA presence and activities in these fields are very important and provide a unique added value.

UNFPA in the 4th CP played a critical role in the establishment of the FHH and fundraising efforts to expand the same, in addition to capacity building of community midwives, targeting the hard-to-reach areas and marginalized populations makes a big difference in reducing maternal mortality rate in the country while at the same time contributing to the healthcare workforce capacity. By targeting areas not being targeted by BPHS and EPHS makes the contribution stand out as significant for the country's health sector performance (interviews with MoPH, IPs and annual reports). Further, the 4th CP greatly contributed to the work of the MoPH in development of SOPs, capacity and resourcing in the areas of gap in relation to RHR, and were uniquely identified as critical contribution by the various stakeholders interviewed. UNFPA's lead role in supporting implementation of family planning and RMNCH were recognized by the respondents. UNFPA's comparative advantage as the sole contributor in addressing obstetric fistula treatment and prevention in the country is greatly recognized by the stakeholders. At the onset of COVID-19, UNFPA enabled the maternity hospitals to operate by averting closure due to fear for safety of the

healthcare workers by supplying the facilities with PPEs and other medical and non-medical items (interviews with MoPH, UN and CO staff).

UNFPA is the single UN agency in Afghanistan with focus on data, enhancing inclusion of population dynamics in development, planning and implementation policies and programmes, through data generation and analysis; leading to evidence-based decision-making in the country, and in the areas targeted. The NSIA recognizes the role played by UNFPA in strengthening its capacity to deliver in its national mandate as unique and competent. Through financial and technical support of UNFPA during the 4th CP, the country's population, which has been inconsistently referenced, can reliably be estimated through the use of satellite imagery technology, and used for planning in development. In addition, stakeholders reached and document reviews identified UNFPA's contribution in the SDGs indicators for Afghanistan through the production of disaggregated data. The capacity building of the various ministries and KU in the demographic and statistical capacity is unique and helps in strengthening the country's capacity in evidence-based programming (Interviews with NSIA, KU, RC and CO staff).

Another great advantage as perceived by the stakeholders is related to their proven ability to do rapid assessments and response in emergency situations, such as the influx of returnees 2015 and 2016, and displacements due to disaster and conflicts in the country. UNFPA was able to mobilize resources to enable prompt response to the emergency and humanitarian situations, including prepositioning of the dignity and emergency RH kits in all the regions (Interviews with CO, IPs staff and document review). The capacity building of the country's humanitarian stakeholders on MISP and provision of SOPs and guidelines enabled standardized and quality response to the situation, which was unique to UNFPA, confirmed by MoPH and UN agency staff.

UNFPA Afghanistan's recognition in the health sector response to GBV is considered a unique contribution given the contextual challenges in addressing GBV as a non-health issue, allowing a buy-in by the various stakeholders, especially duty bearers, who are mostly conservative towards empowerment of women and girls to access services and exercise their rights. Further, UNFPA's support in strengthening the capacity of the police sector to enhance case management in GBV response, and establishment and support of FPCs and WFHS was lauded as worthwhile (Interviews with MoWA, MoPH, MoI, Donors and UN agencies interviewed). The leadership of UNFPA in the GBV sub-cluster, as well as facilitating establishment of the GBV IMS within the country significantly strengthened case management and leveraging of resources to enhance access and quality response to the survivors (Interviews with CO, MoPH, MoWA and reports).

UNFPA made a significant contribution in targeting the youth through facilitating provision of adolescent and youth-friendly health services, and advocating for their unique needs in the country adds a lot of value. UNFPA was recognized for influencing both government authorities and donor agencies to prioritize youth and adolescents' rights and needs at national level, in addition to leading in coordination of youth issues through chairing the IANYD at the UN level ((Interviews with UN agencies, DMoYA, MoPH). UNFPA was also recognized by the respondents from the MoPH and DMoYA in the greatest contribution to the mental wellbeing of the youth people through provision of psychosocial and, the first of its kind, premarital counselling during the period of evaluation. In addition, the Youth Parliament immensely contributed to the empowerment of the youth and advocacy on youth issues, leading to recognition of the importance of involving youth in key decision-making roles by the government and the community at large. The financial and technical support to the development of National Youth Strategy, National Youth Policy, the National Child and Adolescent Health Strategy, and the National Action Plan to eliminate child Marriage were significant for the country's young people and the government (Interviews with DMoYA, RC, CO and UN agencies and SIS).

UNFPA Afghanistan is particularly valued for its technical expertise in the areas of responsibility, transparent, collaborative, effective and flexible

work style among the stakeholders, which makes it a valuable stakeholder to partner with.

Even though UNFPA made significant difference in the country, most of which could not be done without its technical and financial support, there are opportunities for improvement and strengthening its contribution in the country. Some of these are in the areas of staff capacity in the areas of mandate; resource mobilization to cover more gaps like establishment and integration of the FPCs at the district and community health systems, expansion and advocacy for integration of the FHHs into the country's health system, and youth-friendly services, and finalizing the SDES in the remaining 21 provinces, among others.

4.8 Coverage

EQ 9: To what extent has the UNFPA humanitarian response reached those most in need and vulnerable in crisis situations both geographically and demographically?

Summary of Findings: UNFPA humanitarian programme clearly responding to the needs of the vulnerable populations, especially the migrants, IDPs and those in the hard-to-reach areas. UNFPA humanitarian response also effectively responded to situations of disaster and emerging humanitarian issues. In addition, UNFPA contributed to development of preparedness plans across the country, enhancing reach of the affected populations

During the 4th CP, UNFPA contributed to strengthening access to RH and GBV services in the humanitarian settings, especially targeting populations affected by crisis, disasters and vulnerable populations, including women and girls. This was effected through supporting capacity strengthening of various stakeholders, including the government line ministries and non-state actors along CP components; thematic programme strategy development; provision of population data for needs identification and response; RH supplies and health facility support; and strengthening multisectoral coordination of GBV and RH service provision in humanitarian settings (Interviews with CO, line ministries and agencies, UN staff and SIS).

UNFPA generally contributed to the national response on humanitarian response, especially during crisis situations in close coordination with other stakeholders like UNOCHA. In partnership with the ARCS, UNFPA reached all the 34 provinces with RH and GBV services during humanitarian crisis. In this partnership, UNFPA trained the ARCS on the various competencies of the MISP to deliver in the thematic areas of responsibility. UNFPA also supported ARCS with supplies, including prepositioned dignity and emergency RH kits in warehouses in all regions, in preparation for any arising crisis. The extent of the CP coverage with the service is a challenge ascertaining as data and the extent of need was not clear and not harmonised among the stakeholders (interviews with IPs and CO staff, and document reviews).

UNFPA's focus on strengthening the capacities of the humanitarian actors in the country was reported to have contributed greatly to improving the quality of response and coverage of services provided to the people affected by crisis (Interviews with MoPH, IPs and CO staff). UNFPA enhanced capacity of GoIRA through supporting development of the emergency preparedness plan, provision of emergency preparedness and MISP training to MoPH (including provincial RH officers), IPs, CSOs and other actors in the country, including BPHS and EPHS partners (Interviews with MoPH and CO and CO reports), giving the programme a wider coverage and reach with services and response. It was however not easy to establish the extent of utilization of the enhanced capacity in responding to emergency situation. Support to the MoPH and ARCS in distribution of RH and dignity kits supplies and availability of service points through MHTs provided wider coverage by the 4th CP in the affected areas as shown in section 4.3.1.3 (Interviews with IPs and CO staff). During crisis, UNFPA responded through supporting MHTs and provided supplies to the affected health facilities for a quick response to the

affected populations, in addition to provision of life-saving RH services to the crisis-affected populations.

During the 4th CP implementation UNFPA contributed to maternal health aspects of the Afghanistan National Health Disaster Management Plan, with a national coverage facilitating targeting of vulnerable populations. Interviews with the CO, MoPH and IPs staff indicated that UNFPA ensured that people in crisis situation got relief through support with essential service package.

As a member of the HCT, UNFPA contributed in advocating for allocation of more funds to address Reproductive health needs of the populations in crisis. There is also evidence of increased budget allocation for RH services in the HRP (Interviews with SC members and UN agency staff). In addition, reports show UNFPA mobilized more resources to cover needs of the hard-to-reach and marginalized populations. For example, during the implementation of the 4th CP, UNFPA expanded FHH facilities from 82 at baseline to 146, expanding to five more provinces based on the needs. For example, in 2016 during the unexpected influx of returnees from Pakistan, UNFPA reprogrammed using the available core resources and mobilized Central Emergency Response Fund (CERF) to provide emergency lifesaving RH services at the border entry points as well as in conflict-affected areas through MHTs, effectively providing integrated RH and GBV services to the returnees. (Interviews with MoPH, CO staff and CO reports). While this was a great improvement in coverage with RHR services targeting the hard-to-reach and marginalized populations, the level of coverage vis-a-vis the needs were limited by resources available and affected by inaccessibility issues (Interviews with CO, MoPH and reports). UNFPA also responded to returnees' influx and IDPs needs through establishment of FPCs in Herat, Nimroz and Kundoz provinces (Interviews with CO and IPs and SIS). While interviews indicated existence of male GBV survivors, the structure of the referral mechanism did not give them prominence, including the FPCs not having male staff to support them (IP and CO interviews).

As the lead agency in data generation in the country, UNFPA contributed immensely in the identification of needs through conducting needs assessments and population-based surveys, informing humanitarian response based on the disparities. UNFPA also contributed the data that informed the HRP and HNO. Interviews with the CO staff revealed that HRP was constantly updated in case of changes in the needs identified, making sure that the needs of pregnant women are covered in the HRP (Interviews with RC, CO and SIS).

At the onset of COVID-19 pandemic, UNFPA procured PPEs, including medical and non-medical supplies for all the maternity hospitals and supporting the government to produce IEC and other knowledge materials on COVID-19 IPC, ensuring continuity of the maternity services without interruption across the country; amid initial concerns by the healthcare workers, mainly midwives, about their safety. UNFPA also pitched camps for screening the returnees arriving from other country through the border provinces of Mazar, Konduz, Herat and Nimruz (Interviews with MoPH and CO).

As the lead agency of GBV Sub-cluster, UNFPA contributed to supporting delivery of coordinating GBV response among the members, in addition to contributing in development of SOPs and guidelines for service delivery, contributing to effectiveness and quality of service to the people affected. UNFPA was also a member of a joint programme with WFP in Jalalabad funded by DFTD (Australia), where UNFPA is responsible for RH and psychosocial support to the affected population in Nangarhar province. UNFPA is also a member of national and provincial coordination mechanism ensuring that humanitarian services were delivered in a coordinated manner including coverage of RH and GBV services (Interviews with the CO, MoPH and WFP staff).

While UNFPA made efforts to ensure there was effective coverage or response to the people affected by crisis in different geographical locations of the country, the extent of delivery varied and influenced by a number of factors. Respondents also indicated weaknesses in the data shared on the affected population during disaster and conflicts as they were not harmonized. UNFPA however addressed this through use of satellite imageries to map households and provide estimates. While UNFPA partnered with ARCS, in addition to strengthening their capacity on hu-

manitarian response, there were inherent weaknesses in capacity to effectively deliver in their mandate which necessitated constant training (CO interviews and reports). Coordination was also reported not to be effective as there were parallel mechanisms in place led by the UNOCHA and the government-led one coordinated by ANDMA, and these had different strengths in different provinces. To ensure being abreast with the coordination messages, UNFPA attended both coordination meetings (Interview with CO and reports). Access to some of the locations were also hindering factors in reaching various geographical locations with vulnerable and needy populations. Financial and human resources, especially in getting qualified midwives in the remote areas were also constraining factors to coverage. Establishing effectiveness of the training was also challenging to ascertain. While the humanitarian programme was implemented in an integrated manner, there was no or little mention of particular programmes targeting the adolescent and youth, save for the nationwide youth health line.

4.9 Connectedness

EQ10: To what extent does UNFPA humanitarian action and plan for longer-term development goals articulated in the results and resources framework of the 2015-2021 Country Programme and contribute to resilience building?

Summary of Findings: The 4th UNFPA CP contributed to strengthening capacities of the actors, development of strategies, guidelines and policies to guide implementation, coordination and promoting integration of programmes and national ownership of interventions and results.

UNFPA contributed to the development of various policies, strategies, SOPs, guidelines, supporting coordination of programming, ensuring long-term service delivery and contributing to laying a foundation for a lasting solution to the humanitarian situation in Afghanistan. UNFPA 4th CP is aligned and contributes to the Afghanistan National Priority Programme and the Afghanistan Peace and Development Strategy which seek to strengthen and address the Afghanistan humanitarian and development ensuring lasting peace and prosperity. In addition, UNFPA supported and contributed to the localization measurement of the SDGs, especially SDG 17, 16, 10,5, and 3, leading to sustainable development, which is long-term (Interviews with MoPH, MoEC, RC and CO, and annual reports).

During the 4th CP, UNFPA contributed to the development of capacities of various humanitarian stakeholders to enable them deliver effectively in the context of implementation. UNFPA technically and financially supported the ANDMA to develop the National Disaster Management Plan, which included aspects of early warning mechanisms, strengthening response and limiting dire effects of the shocks that come with the disaster experienced in the country. In addition, UNFPA was responsible for the implementation of the RH components of the plan where there was immense contribution in the capacity of the stakeholders, led by the MoPH (Interviews with CO, MoPH and reports).

At the onset of emergency crisis, UNFPA deployed MHTs in the affected communities for life-saving RH services. Interviews with the IPs and CO staff indicated that UNFPA ensured transition of provision of the life-saving to comprehensive RH service delivery through supporting the nearest health facility to deliver the services to the affected, including capacity building and supplying them with medical and non-medical supplies. On the other hand, UNFPA's support to the establishment and operation of the FHH contributes to peace and stability as they are seen as the face of the government through the initiatives in those communities. The support of NSIA to produce data and capacity building also contribute to stability (Interviews with CO, MoPH and IPs).

In the implementation of the 4th CP, UNFPA strategically partnered with the government structures (line ministries and authorities) supporting them to deliver in their strategies, contributing directly to their enhancement on delivery mechanisms. On the other hand, UNFPA partnered mostly with local NGOs as IPs, strengthening

their capacities to be able to deliver the services when disasters occur and after and ensure continuity of the services. Through partnership and advocacy mechanisms, UNFPA ensured national ownership of the programme interventions in addition to the results. While ownership was evidenced in the implementation and delivery processes, the capacity of the national and provincial institutions, including line ministries still remain weak, in systems, financial and human resources, limiting the likelihood of effective operationalization of the gains made during the 4th CP. For example, there is a high dependence of the government on foreign grants, like in the health sector which is purely dependent on multilateral and institutional donors like Canadian Government, DfID, European Commission, World Bank, among others (Document review and interviews with MoPH, CO and IPs staff).

UNFPA successfully technically and financially supported strengthening of the capacities of the humanitarian actors through development of guidelines and tools to enhance quality service delivery in the health sector. UNFPA supported the review of the RMNCAH guiding RH service delivery including in the humanitarian context, to include adolescent and youth health, in addition to the youth-friendly service guideline for healthcare workers, taking into consideration the ARH (Interviews with CO, line ministries and IPs Staff). These will enhance advocacy that influence health-service delivery in the country, including strengthening the humanitarian service delivery.

The development of the National Youth Strategy and National Youth Policy, with financial and technical support from UNFPA provided a roadmap to ensure meaningful and inclusive participation of youth people in peacebuilding and governance. This led to a lot of changes in the country with regards to perception and targeting the young people for meaningful engagement, including averting cases of possible recruitment into the armed groups in the country, out-migration, despondency among the youth in the country (Interviews with DMoYA, MoPH, IPs and CO staff).

UNFPA made deliberate efforts to build the capacities of the various national stakeholders on quality RH service provision, GBV response and on data generation and service mapping of the vulnerable populations including IDPs, women, girls and marginalized population, skills that will continue to remain with the beneficiaries, enhancing resilience. Through the PD component of the 4th CP, enhanced access to data in humanitarian settings which can trigger early warning and early action to avert the recurrent shocks from disasters.

While there were efforts to ensure strengthening humanitarian-development-peace nexus, Afghanistan is still volatile, plagued with displacement, conflicts and uncertainty on the roadmap to peace. Inadequacy of rights awareness, weak local governance, legal and legislative capacity continue to hinder response and may take a long time to realize change. The absence of the humanitarian strategy in the country may limit response and sustainability and continuity of the results gained during the 4th CP (Interviews with CO, UN agencies and government line ministries).

4.10 Unintended Effects of the CP Implementation

The consultants also looked into the achievement made in the implementation of the programme, but were not planned for in the design of the programme. The following were identified:

I. **SRHR Unintended effects:** The establishment of the FHH enabled provision of EPI services through UNFPA and UNICEF partnership, with the FHH providing space for the same. At the time of the CPE, the UNICEF and UNFPA were planning to initiate provision of nutrition services. Further, UNDP funded establishment of FHH in two more provinces, based on the results derived from the same.

II. **A&Y Unintended effects**: The development of the National youth strategy and policy led to development of New Framework for Higher Education which would guide the policy on fresh graduates' engagement in internship, increasing their employability. The development of the National youth strategy also eliminated overlaps among the UN agencies as it spelt clearly on the areas of focus on youth issues.

III. **GEWE Unintended effects:** The integration of the UNFPA-supported manual on the police sector approach to GBV's into the Police Training Academy enabled orientation of the new recruits on GBV and this would make it easier for their increased knowledge and awareness on the same.

IV. **PD Unintended effects:** There was none notable.

4.11 Lessons learnt and Best Practices

I. Collaboration and coordination between the UNFPA, government and other cooperating partners was very critical for delivery of the UNFPA programme in the country.

II. Creating a thematic area for the integrated RHR and GBV response in the humanitarian sector is well justified given the protracted nature of the context and the propensity to disaster, thereby necessitating planning, in addition to dedicated allocation of resources for an effective response by the CO.

III. The Family Health House (FHH) is a unique approach to reach the end of the underserved areas to ensure no one is left behind; the furthest the first; and the universal health coverage to RMNCH services.

IV. Similarly, the backup of community midwives to cover the absence of FHH's community midwives was noted a positive point as without having the backup midwives, the services will be paused especially during maternity leave of midwives.

V. The involvement of communities and local authorities in the design and implementation of the family health houses enhanced ownership and led to contribution of the communities in the running of the facilities, including supporting by contributing for transport to make referrals in the absence of an ambulance, in addition to supporting in the monitoring of the interventions in the hard-to-reach areas ensuring the functionality of the health service provision.

VI. Implementation of 4th CP's interventions in the government facilities with services provided by the government employees, like the youth-friendly services, assured sustainability and national ownership, in addition to capacity strengthening

VII. The 4th CP's development of the National Youth Strategy and National Youth Policy enhanced youth targeting and eliminated overlaps among related agencies, with clear mandates provided.

VIII. Integration of the UNFPA developed manual on the police sector approach to GBV's in the Police Training Academy was a great achievement in producing recruits who were already oriented on GBV and would not require much in order to participate in the interventions.

IX. The disjointed nature in GBV case management, with parallel databases is prone to duplication of response, in addition to weak referral pathways can discourage GBV survivors from seeking help.

X. UNFPA's unique mandate in capacity strengthening national capacities in generation, processing, dissemination and utilisation of population data at all levels and to provide high level technical and financial support remains a high value addition to the country and UNFPA CO.

XI. The establishment Afghanistan Parliamentary Forum on Population and Development (APFPD), facilitated realization of demographic dividend in the country through engagement of key population issues further enhancing advocacy for conducive environment for International Conference on Population, and Development Programme (ICPD) Programme of Action and the Sustainable Development Agenda 2030.

CHAPTER 5: CONCLUSIONS

5.1 Introduction

This section presents the conclusions drawn directly from the findings presented in Chapter four, presented with both strategic and programmatic focus, especially based on the evaluation criteria. The strategic level (covering relevance, efficiency, sustainability, coverage, connectedness

and coordination), and programmatic level covering the CP component area.

5.2 Strategic Level

Conclusion 1: The 4th CP is strategically aligned to the national and international development priorities. The Country Office effectively responded to the changing environment and needs, including in the humanitarian settings, and strategically built partnerships within the GoIRA, UNCT, donors and other stakeholders in the country.

The 4th CP was fully relevant and strategically aligned to national and international development needs. The design was well adapted to the needs of the needs of the population, particularly of the most vulnerable and marginalized, responded to the government priorities as contained in the Afghanistan National Development Strategy 2008-13 and is still aligned to the Afghanistan National Peace & Development Framework (ANPDF)[89], national sectoral ministry strategies and the National Priority Programmes. The CP was fully aligned to the UNFPA global Strategic Plan 2018 – 2021, and UNDAF, later One-UN accountability framework. There is evidence of design and implementation of the programme in consultative manner with the participation of the government, local NGOs and beneficiaries, especially at the community level, advancing national ownership and capacity building. It was however not explicit in the CP design on how the most vulnerable were consulted. The 4th CP was responsive to changing national needs and environment especially in the increasing displacement, returnee influx, COVID-19, floods and drought. UNFPA is seen as a highly respected and valued partner in both national and county levels of government and among other stakeholders. During the 4th CP, the UNFPA developed innovative partnerships, including with the National Parliament, facilitating advocacy mechanisms leading to enactment of laws in the country. There is however an opportunity to strengthen strategic partnership for ownership of the CP results.

Associated Recommendation: 1

Origin: EQ 1, EQ 2, EQ 3, EQ 6 **Priority**: High

Conclusion 2: UNFPA demonstrated in the 4th CP a comparative advantage in the areas of mandate, especially in supporting evidence-based programming, advocacy for GBV response and adolescent and youth programming, and RHR, making great achievements in the country. Limited capacity and commitment of the government limits realization of the intended programme results. Further, there is also inadequate supportive frameworks, especially coupled with slow processes and prioritization of the issues by the duty bearers, limiting progress in improvement in the existing contextual situations.

The CP made a great contribution in its areas of mandate, both technically and financially, leading to development of guidelines, strategies, action plans, policy documents, in addition to contributing to strengthening of various capacities within the government, including supporting service delivery in the areas of need, especially in GBV, RHR, Adolescent and Youth, and PD components. The contributions in strengthening the capacity of the government line ministries and agencies, local NGOs and supporting construction and equipping of service infrastructures were enormous and considered of value to the country. Effectively utilized and implemented, these are likely to create a difference in the country's development and humanitarian framework. UNFPA also utilized SSTC, which yielded a lot of positive results to the country, especially on strengthening the capacity of the country in various programme thematic areas. UNFPA can capitalize on this approach to enhance the capacity of the country on arising areas of weaknesses. Strong socio-cultural factors, inadequate and disjointed engagement frameworks are also hindering implementation of the gained results in the advocacy efforts in policy formulation and implementation. Further, while the CP was implemented in strategic partnership with the government line ministries and agencies, there were inherent inadequacies in capacity in the government, both financial and human resources. This will likely affect implementation and water down the gains made. For example, the OF treatment requires resources to be implemented, while with

[89] Afghanistan National Peace & Development Framework (ANPDF) 2017 - 2021

the government's dependence on external support to provide essential health services, this may not be prioritized, and may lead to surge in the already existing 3% of women affected by OF in the country.

Associated Recommendation 2 **Priority**: High
Origin: EQ 1, EQ2, EQ3, EQ5, EQ 8

Conclusion 3: The 4th CP demonstrated strong commitment to the UNCT coordination and actively participated in the activities of the UN Mission in Afghanistan, with its mandate and priorities well reflected initially in UNDAF, and later the One-UN Accountability Framework, including taking leadership roles in their implementation, in addition to nurturing collaborative and joint programmatic among UN agencies in the country. There were however weaknesses in the coordination among UN agencies, with some competition among the agencies, creating leading to conflicts.

Despite indications of strong UNCT coordination mechanisms, there were issues of disharmony, mistrust and inadequate cohesion among the coordinating UN agencies, especially in the health cluster, where UNFPA was deliberately not recognized in its contributions, in instances of shared roles; and HCT level, where admission of agencies were at times frustrated by the existing ones due to competition or mistrust. Coordination among the UN actors in the humanitarian response at the provincial levels also required presence of each, for inclusion of thematic areas in planning or reporting. This requires strengthening for effectiveness and delivery of services.

Associated recommendation 3 **Priority**: Medium

Origin: EQ 1, EQ2, EQ 3, EQ7

Conclusion 4: UNFPA made considerable achievements in the implementation and achievement of the results, within the constraints of partnerships, capacity and strategic positioning. In addition, there was too much focus on activity level of details that limits capturing and monitoring of results with weak ToC. Integration of the 5th County programme components will ensure efficiency and effectiveness

There was inadequacy in staff capacity in different programme components with some staff overstretched in their responsibilities, in addition to strategic positioning, especially at higher level programme advocacy. Grading of staff, especially in the operations section was also an issue. There is opportunity for the CO to strengthen capacities in every programme unit, in addition to identifying and addressing areas of gaps for more results. The CP implementation and reporting orientation was more based on completing activities and not on the changes arising from the implemented interventions. While there was a deliberate focus on mainstreaming gender, there was inadequate capturing of this in reporting, in addition to very little instance of disaggregated data in reporting along sex, disability, gender, among other aspects to enhance response. The SIS also does not have this option of capturing this, therefore limiting the focus. Further, while there were efforts to mobilize resources from other donors, there was less emphasis on allocation of more resource to the PD component, affecting extent of implementation e.g. SDES targets not achieved, despite this being a unique UNFPA mandate within the UN. Integration was inadequately employed in the implementation of the 4th CP, and this would have enabled budget gaps coverage experienced during the period, in addition to enhancing coverage. Example, there was no indication of integration of the youth components in the humanitarian response programme, which would have enhanced leveraging of resources and widening of coverage of youth issues among the affected populations. There is an opportunity to improve on integration of the 5th CP components to ensure efficiency and effectiveness.

Associated recommendation 4 **Priority**: High

Origin: EQ 1, EQ2, EQ 5, EQ 6, EQ 8

Conclusion 5: The protracted humanitarian situation in Afghanistan, coupled with weak institutions and governance systems, inadequate capacities, poor infrastructure and response systems, limits sustainability and utilization of the CP results under humanitarian response.

While UNFPA made efforts to strengthen capacities by developing strategies, response plans, SOPs and guidelines, among others, the focus on humanitarian-development-peace nexus was limited in the 4th CP implementation. The onset of COVID-19 is also likely to exacerbate the situation

further affecting the already achieved results in the context. These require more strategic focus, building on evidenced response and contextual understanding, for effective and lasting results; and reduce the inherent risks in the humanitarian framework.

Associated recommendation 5 **Priority**: High
Origin: EQ 1, EQ2, EQ 5, EQ 6, EQ 8

Programmatic Level

5.3.1 Reproductive Health

Conclusion 6: UNFPA strengthened FP programming in the country using various health system strengthening approaches, including capacity development. The CPR indicator is still low due to non-prioritization of FP by the government, inadequacy of government funding to reduce commodity stock-outs and inadequate commitment in the management of the RH commodity supply chain. In addition, there was low utilization of the FP methods despite high level of awareness, linked to deeply-rooted social norms and will require stronger and specifically targeted SBCC strategies to address the arising gaps.

While awareness level on family planning methods is over 90 percent, utilization is still low and stagnant at less than 20 percent, implying that the knowledge level is higher, while the demand for the services is lower. Behavioural and deep-rooted cultural issues were cited to be affecting uptake of the services, requiring more advocacy. Adequate commitment by the government, including prioritization and increased funding of FP interventions should provide enabling environment for improved utilization of the FP services in the country. Further, strengthening SBCC approaches, targeting specific behavioural and social norms in target communities will contribute to increased uptake of the FP services.

Associated recommendation 6

Origin: EQ 1, EQ2, EQ 3 **Priority**: High

Conclusion 7: The 4th CP immensely contributed to increasing access to RH services by the marginalized and vulnerable populations living in the hard-to-reach locations through establishment of health service centres, strengthening capacities of service providers and development of guidelines and SOPs for standardized quality of services delivered. This support also brought in opportunities for provision of more essential health services in the areas like the EPI. On the other hand, integration of the service centres (FHHs) into the mainstream service delivery is taking too long, with little government and donor commitments on the same. Further, there were also concerns on the inadequacy of existing capacities to provide Obstetric Fistula services, in addition to limited attention on the social re-integration of fistula survivors.

UNFPA 4th CP successfully contributed to addressing the needs of most vulnerable and marginalized populations for increasing their access to skilled birth attendance through the implementation of the family health house (FHH) initiative. Further, UNFPA supported the human resources capacity development by selecting, enrolling, and training community midwives, and ultimately deploying them to the established FHHs. While there were initiated discussion to integrate FHH into the health systems of the country, financed through the government programmes, the process is quite slow. There is also need to continue expanding the facilities to other white areas in the country to cover more vulnerable and marginalized populations in the hard-to-reach areas. On the other hand, there is still a high burden of obstetric fistula, while the existing capacities of the trained surgeons are still inadequate, including response facilities, including the need for strengthening mechanisms for social reintegration of the survivors to address OF stigma.

Associated recommendation 7 **Priority**: High
Origin: EQ 1, EQ2, EQ 3, EQ5, EQ7

5.3.2 Adolescent and Youth

Conclusion 8: UNFPA strengthened adolescent and youth access to integrated RHR and GBV services through increased strategy and policy development, in addition to capacity building of stakeholders to provide the services. Inadequacy of or weak coordination among different implementation ministries delays progress of the strategies, in addition to inadequacy of funding for the strategy and policy to implement

The development and approval of the National Youth Strategies and policy during the 4th CP laid foundation for a meaningful engagement of the youth in productive processes, including paying attention of the plight of the youth in the country. With this development, a number of youth targeting was enhanced, all aimed at addressing the needs of the youth to ensure they benefited and contributed to the building of the nation. The implementation of strategy and policy involves coordination among nine government ministries and agencies, which has proven to be weak and slow in decision-making, in addition to being ineffective. This can be counter-productive to the potential that the documents portend to have for the youth in the country. Resource allocation for the implementation of the strategies and policies are also inadequate, and dwindling.

Associated recommendation 8 **Priority**: High
Origin: EQ 1, EQ2, EQ 3, EQ4, EQ5

Conclusion 9: The 4th CP has strengthened policies, strategies and programmes addressing the integrated RHR needs, knowledge, demands, access to and service provision for young people, particularly adolescent girls and young women. Active engagement of young people and strengthening of youth networks in advocacy, programming and demand creation has potential for impact in increasing their role in state and peace building, awareness and uptake of ARH services. Greater resource allocation is needed to intensify this focus in the 5th CP. Further, integration of FLE into the school curriculum experienced coordination and financial challenges between MoPH and MoE.

The 4th CP has greatly contributed to addressing the RHR needs of the young people through strengthening policy and strategy development and addressing barriers to their access to the RH services, expanding their knowledge and demand for RHR services. UNFPA also exhibited the power of structured youth engagement through the Youth Parliament Platform, which culminated into myriad of results at the end of the day, increasing their profile in the country. Resource allocation for the component, both financial and human capacities was however low compared to the needs of the youth, given their proportion in the country. In addition, there is need to strengthen systems and structures to increase focus on the youth issues and reap the potentials that the youth have in contributing to the development of the country. Further, UNFPA CP relied on ministry-to-ministry coordination approach to work on the integration of the FLE into the school curriculum which never worked well, stagnating the intervention; and will necessitate a more proactive approach to enhancing coordination among the ministries and stakeholders.

Associated recommendation 9 **Priority**: High
Origin: EQ 1, EQ2, EQ 3, EQ5, EQ7

5.3.3 Gender Equality and Women Empowerment

Conclusion 10: There is strengthened health and police sectors' responses to GBV through enhanced capacity and increased engagement and awareness among the law enforcement stakeholders, in addition to development of guidelines and SOPs, and community engagement. There is however disjointed response among stakeholders, weak multisectoral coordination and referral pathways, in addition to weak and unavailability of supporting legal frameworks for implementation to enhance access to GBV response services by the survivors.

While UNFPA made considerable achievement is the area of GBV response, the coordination at the sub-cluster level is sub-optimal. Currently, there is no framework for coordinated case management. Further, the referral pathway is also not strong despite the efforts put in place to strengthen response. The partnership is disjointed and cases are addressed in silos. The disjointed response among the stakeholders, weak referral and service delivery mechanisms and inadequacy in the law criminalizing GBV discourages reporting of cases. Addressing GBV requires a coordinated response that promotes changes at different levels and lessons learned in this broad complex area, in addition to leveraging resources and limiting overlaps, in addition to enhance utilization of the GBV IMS leading to harmonization of data in GBV response.

Associated recommendation 10

Origin: EQ 1, EQ2, EQ 3, EQ5. **Priority**: High

Conclusion 11: The CO increased discourse on socio-cultural norms, but insufficient strategies for evidence-based response. Deliberate programmes targeting the male segment of the population and the community level duty bearers is conspicuously missing or inadequate.

UNFPA contributed to strengthening GBV prevention and response interventions, especially in addressing the socio-cultural beliefs that perpetuate discrimination, disinheritance and violence against women and girls. There was however inadequate investment in research, bringing out the root causes of the problems and addressing them, in addition to insufficiency in targeting both men and boys in the country, in addition to the engagement of the duty bearers on elimination harmful practices against women and girls.

Associated recommendation 11
Origin: EQ2, EQ 3, EQ4, EQ5 **Priority**: Medium

5.3.4 Population Dynamics

Conclusion 12: While there were strides made in the generation of data, in addition to development of strategic policy briefs and papers, there is still weak integration of population dynamics into development planning.

Apart from strengthening data generating data, little effort, if any to show integration of the population dynamics into the development sectoral policies and programme. There are opportunities to harness the benefits of population in planning for development and humanitarian response.

Associated recommendation 12
Origin: EQ2, EQ 3, EQ5 **Priority**: High

Conclusion 13: The 4th CP strengthened population data systems for programming and policy dialogue, including introduction of technology in data capturing, significantly addressing contextual challenges, including insecurity, access and population estimation issues in Afghanistan. There is however need to harmonize data generation techniques, including continued engagement and sensitization of the government and other stakeholders in the processes to facilitate decision-making.

Despite strong performance by the 4th CP to strengthen the capacity of the country and increase availability of disaggregated data for policy formulation and development, dissemination and utilization was reported to be weak. To strengthen utilization of the data to inform policy, especially in the absence of the actual field data collection, there is need to sensitize the government, in addition to advocating for harmonization of data sources.

Associated recommendation 12

Origin: EQ2, EQ 3, EQ5 **Priority**: High

CHAPTER 6: RECOMMENDATIONS

6.1 Introduction

This chapter presents the recommendations of the Country Programme Evaluation (CPE) along strategic and programmatic considerations based on the findings, conclusions and feedback from the CP stakeholders. The recommendations are classified into high and medium priority. High priority refers to implementation within a 1-2-year period whilst medium priority refers to implementation within 3-4-year period. Implementation of the recommendations would also require increased resource allocation to strengthen the role of the CO to provide technical support, as well as avail additional funding to IPs.

6.2 Strategic Level

Recommendation 1: UNFPA should prioritize wide consultations to enhance strategic alignment of the 5th CP to the Afghanistan's national development and humanitarian priorities, as well as to the international and regional normative frameworks to respond to the country's needs and priorities, in addition to strengthening national and international partnerships in the development and humanitarian framework for effective delivery.

Associated Conclusion: 1
Origin: EQ 1, EQ 2, EQ 3, EQ 6 **Priority**: High

Operational Implication: Wider and continuous consultation during programme design and implementation respectively will enhance evidence-based response to the felt needs, in addition to facilitating relevance and ownership of the programme results leading to sustainability. The partnership approaches worked well during the 4th CP and should continue in the 5th CP, but with expanded engagement of strategic partners, including increased consultation of the most vulnerable and marginalized populations to enhance efficiency, effectiveness and sustainability.

Recommendation 2: UNFPA Afghanistan should enhance strengthening of capacities, including the implementing partners and within the CO itself to ensure evidence-based programming, while at the same time supporting advocacy mechanisms for increased resources allocation in the areas of Adolescent and youth, RHR, GEWE in development and humanitarian planning. In addition, encourage strengthening of institutional capacity building and policy formulation; financial planning mechanisms and broadening funding sources to cover funding gaps that arise due to donor situations and enhance sustainability.

Associated Conclusion: 2
Origin: EQ 1, EQ3, EQ5, EQ 8 **Priority**: High

Operational Implication: Strengthening of national capacities should lead to enhanced programme delivery in an efficient manner, with clear understanding of the programme interventions. UNFPA should also enhance strengthening financial and resource planning at CO level to reduce funding gaps in the delivery of the CP, in addition to broadening funding sources to increase resource base for smooth implementation of the interventions and strengthen partnership and accountability in the delivery of the programmes. UNFPA should continuously strengthen the capacities of the national stakeholders, government and IPs, in their various areas of weaknesses, especially institutional capacity strengthening.

Associated Conclusion 2: **Priority**: High
Origin: EQ 1, EQ2, EQ 3, EQ5

Recommendation 3: UNFPA should maintain its proactive role in the functioning of the UNCT coordination and One-UN, explore opportunities for joint programming and advocate for more accountability among UN agencies, especially for the marginalized

Associated Conclusion: 3
Origin: EQ 1, EQ2, EQ 3, EQ7 **Priority**: Medium

Operational Implications: It is recommended that the CO maintains and strengthens partnerships with the UN agencies in the spirit of Delivering as One for pooled resources to support joint interventions within the UNCT. In addition, there is need for enhanced coordination among UN partners for elimination of overlaps and complementarity in response**.** UNFPA CO should utilize its comparative advantages to enhance evidence-based programme while mainstreaming gender and human rights in the One-UN framework. In coordination with the fellow agencies, UNFPA CO should build strong partnerships and networks within the UNCT for joint programme and high level advocacy, including effective targeting the PWDs. There is also need to advocate for more coordination and collaboration in the areas of niche to realize maximum benefits to the targeted population, and minimize competition.

Recommendation 4: UNFPA to reassess its institutional capacity, guided by the strategic positioning in the country, identify gaps, especially on human resources and implement the findings. Further, the 5th CP needs to be premised on a ToC with clear changes underlying the results chain. Further, UNFPA need to prioritize integration of the programme components for efficiency.

Associated Conclusion: 4
Origin: EQ1, EQ2, EQ5, EQ6, EQ8 **Priority**: High

Operational Implications: Conduct institutional capacity assessment, guided by the strategic positioning in the areas of mandate, consider strengths, weaknesses, opportunities and threats (SWOT), identify gaps then plan on how to implement it, in addition the need of strengthening the capacity of the staff in the capacity gaps identified. There is also need for the 5th CP to be designed and implemented with a strong orientation of results to facilitate accountability among stakeholders; ensure focus on higher level results based on a well-thought it results chain with measurable outputs and outcomes; and in the context of COVID-19 there is need to prioritize investing in disaggregated monitoring data and TPM, in addition to using other mechanism for verification. In addition, integration of the 5th CP components will enable achievement of results, ensuring coverage of funding gaps, thereby enhancing efficiency in the delivery of the programme.

Recommendation 5: Prioritize capacity building, systems strengthening and community level engagement to facilitate humanitarian-development-peace nexus and resilience-building in the country, including durable solutions to the IDPs and refugees. In the context of COVID-19, strengthen capacities of the community level stakeholders to take responsibilities for ensuring effective delivery of services, strengthen community structures, including government to enhance oversight role in the programme implementation processes and strengthen localized coordination mechanism among stakeholders in a particular locality for ease of coordinated response.

Associated Conclusion 5
Origin: EQ 1, EQ2, EQ 5, EQ 6, EQ 8 **Priority**: High

Operational implications: More resources allocated for institutional capacity development of the various partners, continue strengthening the capacities in systems implementation and management and advocate for youth participation in governance and state building, and strengthening collaborations on strategies to realize lasting solutions to the IDPs and reintegration of the Afghan refugees. In addition, strengthen capacities of humanitarian-affected population to enhance their resilience. To address COVID-19-related challenges, strengthen capacities of the community level stakeholders to take responsibilities for ensuring effective delivery of services; strengthen community structures, including government to enhance oversight role in the programme implementation processes; strengthen communication plans to ensure adequate communication regarding COVID-19 and community mitigation measures; advocate for strengthening coordination mechanism among stakeholders in a particular locality for ease of coordinating response; and where necessary, adjust internal controls to be reflective of the reality on the ground to facilitate ease of compliance.

6.3 Programmatic Level

6.3.1 Reproductive Health

Recommendation 6: Support the scale-up of strategies and interventions to address the unmet needs for Family Planning.

Associated Conclusion 6 **Priority**: High **Origin**: EQ 1, EQ2, EQ 3

Operational Implications: Increase investment in mobilization of the social structures (women civil society, youth associations, journalists, and religious leaders) and family structures (especially men) to influence decision-making on use of FP methods, strengthen the capacity of the government to enhance policy and strategy implementation, advocate for increased government investment in FP programming to address the resource gaps arising during the 4th CP, and continue promotion and utilization of evidence-based programming to inform decision-making in the programme. UNFPA should also strategically strengthen the SBCC mechanisms targeting social norms.

Recommendation 7: UNFPA should actively engage MoPH and donors to support midwifery capacity strengthening to increase access to skilled birth attendance. Key is to support integration of the FHH into the mainstream government health systems and increase resource mobilization efforts to enhance its expansion to the marginalized and hard-to-reach areas. Strengthen the capacity of the government to treat Obstetric Fistula survivors, in addition to supporting social integration for the fistula survivors.

Associated Conclusion 7 **Priority**: High
Origin: EQ 1, EQ2, EQ 3, EQ5, EQ7

Operational Implications: Scale up the efforts in advocacy for integration and expansion of the FHH into the mainstream government health facilities and the remaining marginalized and hard-to-reach locations; strengthen capacity of the MoPH to generate resources and to be able to deliver in their national mandate and strengthen partnerships with potential donors to finance the mainstreaming of services. UNFPA should strengthen South-South Cooperation to support training of the healthcare workers in the country for advanced capacity in OF cases identification, referrals and treatment; increase resources for OF treatment, in addition to strengthening social reintegration of the survivors for acceptance at the community level through working with the community level leadership to sensitize the communities.

6.3.2 Adolescent and Youth

Recommendation 8: Advocate for strengthened coordination among the National Youth Strategy and Policy implementing ministries, including development of a national action plan for the implementation of the same assigning roles and time lines for implementation of the key intervention areas. Further, advocate for resource allocation by the government for the implementation of the strategy and policy.

Associated Conclusion: 8 **Priority:** Hgh
Origin: EQ1, EQ2, EQ3, EQ4, EQ5
Operational Implications: UNFPA should emphasize joint advocacy, especially using the UNCT mechanisms for strengthening of the coordination in the implementation of the National Youth Strategy and Policy. Enhance partnerships and capacities among the strategy and policy implementing ministries and agencies to facilitate coordinated implementation. There is also need for the stakeholders to advocate for development of an implementation action plan, in addition to resource allocation for the implementation and coordination mechanisms.

Recommendation 9: UNFPA to strengthen partnerships and coordination to enhance capacities to increase integration of youth- and adolescent friendly RH information and services and reproduction rights. Strengthen mechanisms aimed at increased engagement and mainstreaming of youth participation and interventions in the country. There is also need to strengthen integration of FLE into the school curriculum.

Associated Conclusion: 9 **Priority:** Medium
Origin: EQ1, EQ2, EQ3, EQ5, EQ7

Operational Implications: Strengthen advocacy mechanism to increase integration of youth and adolescent friendly services, including FLE integration, enhance awareness mechanisms at the community level and strengthening enabling environment, and strengthen partnerships among youth-related stakeholders including donors and capacities of YFS providers and strengthen social change at the community for sustainable change. Enhanced consolidation of youth groups and networks in the country; strengthened linkage between the youth and government agencies and youth-related stakeholders; enhancing evidence-based programming in the youth component will be useful towards increasing youth voices and participation in the country's development processes.

6.3.3 Gender Equality and Women Empowerment

Recommendation 10: Advocate for strengthened multisectoral coordination for and quality GBV service delivery, and advocacy for scale-up of policy and legislative framework on GBV response and prevention. In addition, there is need is need to strengthen case management mechanisms, including the referral pathways for GBV response.

Associated Conclusion 10
Origin: EQ 1, EQ2, EQ 3, EQ5. **Priority**: High
Operational Implication: Strengthen advocacy mechanisms to enhance GBV multisectoral and coordinated response at sub-cluster level, including increased investment on the GBV IMS, strengthened referral pathways and track utilization by stakeholders, and improved quality of services delivered to the GBV survivors ensuring that they adhere to the SOPs and guidelines in place by the government, and agreed upon by the GBV stakeholders. Further, there is need for joint advocacy on strengthening the legal and policy framework for GBV response to enable the survivors effectively access justice, information and other related services in the country.

Recommendation 11: Strengthen community level advocacy on prevention of GBV and elimination of harmful practices among the targeted populations, including increasing focus on culturally sensitive approaches to address socio-cul-

tural norms and evidence generation on GBV prevention and empowerment of women and girls. In addition, increase engagement of the duty bearers, especially the community and religious leaders, and men and boys in upholding the rights of the women and girls.

Associated Conclusion: 11
Origin: EQ2, EQ3, EQ4 **Priority:** Medium
Operational Implications: Strengthening community level advocacy on prevention of GBV and elimination of harmful practices among the targeted populations, including use of socio-culturally sensitive advocacy approaches and increased investment in evidence generation and knowledge management will contribute to improvement in GBV prevention and empowerment of women and girls. UNFPA also needs to increase downstream advocacy mechanisms on GBV, especially enhancement and consistent engagement of the duty bearers, particularly community and religious leader, in addition to increased engagement of men and boys in upholding rights, will be key in enhancing women and girls' empowerment.

6.3.4 Population Dynamics

Recommendation 12: UNFPA should enhance strengthening of accountability and commitment of the government and relevant agencies on integration of population dynamics into development and humanitarian response programme and policies' planning and monitoring.

Associated Conclusion 12
Origin: EQ2, EQ3, EQ5 **Priority:** High

Operational Implications: Broaden targeting of the participants for national capacity building, like the national planning departments in various ministries for more advocacy on data generation, analysis, dissemination and utilization. Strengthened partnerships with institutions of higher learning to enhance promotion and use of data for decision-making, and tracking of data utilization by the government to increase accountability on utilization of data for programme and policy formulation. Further, specific identification of the needs of the marginalized populations like A&Y, PWDs, women, IDPS, returning refugees, rural populations, among others will enhance targeting and impact of the programme.

Recommendation 13: Advocate for reinforcement in harmonization of data generation techniques, including embracing enhanced utilization of technology and innovation as a way of addressing the unique contextual challenges in generation of data to address data gaps in the country.

Associated Conclusion: 13
Origin: EQ2, EQ 3, EQ5 **Priority**: High
Operational Implication: Strengthen harmonization of data generation techniques to enhance data standardization and ensuring precision in measuring development and humanitarian response in the country. Further, continued support for utilization of technology and innovation will contribute to addressing the country's data production challenges across development and humanitarian response programmes, in addition to enhancing ownership by the government institutions.

ANNEXES

Annex 1: Terms of Reference

United Nations Population Fund (UNFPA)

Afghanistan Country Office

TERMS OF REFERENCE

For Evaluation of the United Nations Population Fund (UNFPA)

4th Country Program of Support to the Government of Islamic Republic of Afghanistan

2015-2021

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Table of Contents

List of Acronyms/Abbreviations

ACTD	Afghanistan Centre for Training & Development, National NGO
AADA	Agency for Assistance & Development of Afghanistan, National NGO
AfDHS	Afghanistan Demographic and Health Survey
AFGA	AFGHAN FAMILY GUIDANCE ASS-AFG, National NGO
ANDS	Afghanistan National Development Strategy
AGE	Anti-Government Element groups
AMA	Afghanistan Midwives Association
ANC	Ante-Natal Care
ANPDF	Afghanistan National Peace and Development Framework
APRO	Asia and Pacific Regional Office
ARCS	Afghan Red Crescent Society
ARH	Adolescent Reproductive Health
AWP	Annual Work Plans
CPAP	Country Program Action Plan
CPD	Country Program Document
CSO	Central Statistics Organization
CO	County Office
DEX	Direct Execution
DMoYA	Deputy Ministry of Youth Affairs
ERG	Evaluation Reference Group
EM	Evaluation Manager
EO	Evaluation Office
ET	Evaluation Team
EQA	Evaluation of Quality Assessment
EU	European Union
GBV	Gender Based Violence
GDP	Gross Domestic Product
GoIRA	Government of Islamic Republic of Afghanistan
HDI	Human Development Indices
HEWAD	HEWAD Reconstruction, Health and Humanitarian Assistance Committee (HEWAD) National NGO
HNTPO	Health Net TPO, International NGO
ICPD	International Conference on Population and Development
IMC	International Medical Corps, AFG
IPEAD	IPEAD, International NGO
KU	Kabul University
mCPR	Modern contraceptive prevalence rate
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MoEC	Ministry of Economy
MoED	Ministry of Education
MoI	Ministry of Interior
MoPH	Ministry of Public Health
MoU	Memorandum of Understanding
MOVE	Move Welfare Organization (MOVE), National NGO

MoWA	Ministry of Women Affairs
NEX	National Execution
NSIA	National Statistics and Information Authority
OECD DAC	Organization for Economic Co-operation and Development's Develop-
PD	Population Development
PSC	Program Steering Committee
QA	Quality Assurance
SCI	Save the Children International (SCI), International NGO
SDG	Sustainable Development Goals
RH	Reproductive Health
SP	Strategic Plan
TFR	Total Fertility Rates
ToR	Terms of Reference
UN	United Nations
UNCT	UN Country Team
UNDAF	United Nations Development Assistance Framework
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WFP	World Food Program
WHO	World Health Organization
CPE	Country Program Evaluation

Introduction

In 2020, the UNFPA Afghanistan Country Office is planning to conduct an independent Country Program Evaluation (CPE) of the UNFPA 4th Country Program of Assistance to the Government of Afghanistan from 2015-2019 and its extension to 2021.

The evaluation will serve three primary purposes: (i) demonstrate accountability to stakeholders on performance in achieving development results and on invested resources, (ii) support evidence-based decision-making, and (iii) contribute important lessons learned to the existing knowledge base on how to accelerate the implementation of the Program of Action of the International Conference on Population and Development (ICPD) and support the achievement of SDGs. The CPE is aimed at generating an independent assessment of successes, challenges, and lessons learned so that this can feed into the UNFPA new program cycle.

The CPE will be an external, independent exercise undertaken by a team of four independent evaluators and managed by the UNFPA Country Office with support from the APRO M&E Advisor and Evaluation Office in UNFPA Headquarters.

The work of the evaluation team will be guided by the Norms and Standards established by the United Nations Evaluation Group (UNEG). Team members will adhere to the Ethical Guidelines for Evaluators in the UN system and the Code of Conduct, also established by UNEG.

The primary users of CPE will be decision-makers in UNFPA (at country office and relevant regional and HQ units), the Executive Board, and counterparts in the Government of Afghanistan. Additionally, partners among donors (Australia, Canada, EU, Korea, Japan, Italy, the United Kingdom), civil society, private sector, and other sister UN agencies (e.g. World Food Program, [WFP], United Nations Children's Fund [UNICEF], World Health Organization [WHO]) are intended audience for the evaluation results.

The Terms of Reference (ToR) sets out the details of the evaluation process, methodology, outputs, and management arrangements, including quality assurance mechanisms.

Context

Country Situation Analysis

Afghanistan's population, estimated at 29.7 million in 2018[90], with an annual growth rate of 2.03 percent, is among the fastest-growing in the world and accounts for an increase of approximately 375,000 people per year. Afghanistan also has one of the highest Total Fertility Rates (TFR) in the world at 5.3 children per woman[91]. At that rate, the Afghan population is expected to double in 24 years[92]. Due to the relatively high fertility, nearly half of Afghanistan's population (47 percent) is under the age of 15, and 16 percent is under five years.
The country has one of the highest population growth rates in South and Central Asia. If this continues at the same rate, Afghanistan's population is estimated to double by 2030 – that would be unsustainable for many reasons. In a country such as Afghanistan with prolonged conflict, low economic growth and high population growth, the per capita income is shrinking,

[90] Islamic Republic of Afghanistan. National Statistics and Information Authorities. *Afghanistan Statistical Year Book 2017-2018*. NSIA: Kabul. Issue No. 39, August 2018
[91] Central Statistics Organization (CSO), Ministry of Public Health (MoPH), and ICF. 2017. *Afghanistan Demographic and Health Survey 2015*. Kabul, Afghanistan: Central Statistics Organization.
[92] Islamic Republic of Afghanistan. Ministry of Public Health. United Nations Population Fund. *National Family Planning Summit: Reviewing Commitment to the Family Planning Program*. Feb 2019. Kabul, Afghanistan

making the country poorer day by day unless corrective measures are introduced. The population growth poses serious economic, development, peace and national security challenges.

Although the development outcomes of Afghanistan have improved substantially since 2001, the country remains among the lowest income countries with a GDP per capita of $580[93]. Poverty rates remain stubbornly high and have increased over recent years, reaching 55 percent.[94] The economy is not growing fast enough to support significant improvements in living standards, with the rate of GDP growth barely exceeding population growth over recent years[95]. The geographical distribution of poverty and opportunity is uneven. Some areas and groups experience high levels of poverty and exclusion from services and infrastructure. Women and girls continue to face barriers to economic participation and access to services; This problem is compounded by the relatively rapid population growth rate, which is driven by several factors including insufficient access to basic health services, inadequate access to education, and the continued exclusion of women from economic opportunities. High levels of displacement, driven by returnees from neighboring countries and conflict-driven internal displacement, are placing additional pressure on livelihoods and services. Afghanistan remains heavily reliant on grants, which finance around 70 percent of total public expenditure and a trade deficit of around 40 percent of GDP.[96]

The population of Afghanistan is very young. By 2020, the number of school-age children will grow to
5.5 million, by 2.5 million, more than the education system can currently absorb. Unemployment and underemployment are widespread. Afghanistan faces a youth bulge, and there are insufficient jobs for the roughly 300,000 Afghans entering the labor force each year. [97]High dependency ratios
undermine savings. 47.5 percent of the population is aged 15 or below and economically dependent. These means households use their incomes predominantly for consumption and reserve little for savings. Lower savings limit Afghanistan's capacity to grow, with fewer resources available to finance investment.[98]

The labor force is expected to increase by 4 million by 2025. This means that every year, between 480,000- 600,000 new entrants will potentially seek jobs – many more than then the economy can absorb. Around 500,000 young males and a similar figure for young females are already unemployed, most of whom reside in rural areas (72 percent) and have either no (43 percent) or only primary education (26 percent). Seventy-one percent of young people cite unemployment as the biggest problem they face.[99]

Afghanistan's Human Development Indices (HDI) value for 2017 is 0.498— which put the country in the low human development category—positioning it at 168 out of 189 countries and territories.[100] Education and health outcomes continue to lag in many areas. Nearly 70 percent of Afghans are illiterate, with negative impacts on productivity and options for economic development;[101]

[93] The World Bank. *Afghanistan to 2030: Priorities for Economic Development under fragility*.

[94] Central Statistics Organization (2018), Afghanistan Living Conditions Survey 2016-17. Kabul, CSO.

[95] World Bank. Afghanistan Development Update: August 2018. Washington DC: World Bank.2018

[96] World Bank. Afghanistan Development Update: August 2018. Washington DC: World Bank. 2018

[97] World Bank. Preliminary Analysis of Household Data Survey. Washington DC: World Bank. 2018

[98] Central Statistics Organization (2018), Afghanistan Living Conditions Survey 2016-17. Kabul, CSO.

[99] The World Bank. Afghanistan to 2030: Priorities for Economic Development under fragility.

[100] United Nations Development Program. Human Development Indices and Indicators: 2018 Statistical Update Briefing note for countries on the 2018 Statistical Update Afghanistan. Available: http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/AFG.pdf

[101] World Bank. Afghanistan to 2030: Priorities for Economic Development Under Fragility. Washington DC: World Bank.2018

As of 2017, Afghanistan ranked 153 of 189 countries on the gender inequality index.[102] Violence Against Women and Girls are widely prevalent; 56% of ever-married women experiences at least one form of physical, sexual, or emotional violence, mainly from their spouses- even worse, 16% of women age 15-49 report that they experienced violence during pregnancy.[16] Women's Participation in Decision-making is widely low: fewer than half of the women (48%) participate in decision making about their health.[16]

Crime, corruption, and weak rule-of-law are major impediments to investment. A large illicit economy (including opium production, smuggling, and illegal mining) deprives the public sector of resources, undermines productivity, and harms Afghanistan's international reputation.[12]

The conflict has been and remains a central constraint to Afghanistan's development. Afghanistan is still suffering from severe security concerns due to international terrorism, armed conflict and the wide presence of Ani-Government Elements across the country, which has affected the development negatively. Ongoing conflict reduces annual GDP growth by an average of 1.4 percentage points.[103] Ongoing conflict is contributing to socio-economic challenges as follows:

Despite the conflict, Afghanistan's health sector has made remarkable progress over the last decade. This progress has translated into a decline in maternal mortality (638 in 2017[104] compared to 1,600 deaths per 100,000 women in 2002[105]. Maternal health has improved since 2003; a majority (63.8%) of the women have at least one antenatal (ANC) visit during their pregnancy, but only 20.9% had the recommended four or more visits. About half of the women (52.8%) who attended ANC had their first visit in the first trimester. Half of the ANC visits took place at MOPH facilities, either a clinic or hospital. Nationwide, 58.8% of the women delivered by skilled birth attendants, most commonly by midwives. The majority of institutional deliveries took place at MOPH facilities, but private facilities constituted a substantial amount of all deliveries, especially in urban areas and among women with higher education or wealth quintiles.[106]

However, still, there are critical challenges toward universal health coverage in Afghanistan. The Afghanistan National Peace and Development Framework (ANPDF) and the National Health Policy and Strategy identify many challenges. The key challenges include the low level of investment in health, lack of trust, poor quality of services, institutional fragmentation, poor planning, low budget execution rates, inequity in service provision, shortage of qualified health care providers (particularly females), and concern about sustainability. Still, around 41.2% of deliveries take place at home; this is especially higher among women in rural areas, lower educational levels, and lower wealth status. Their births are mostly attended by TBAs, a relative, neighbor or friend. The prevalence of modern contraceptive prevalence remained stagnated at 17.4%. Overall, 25 percent of currently married women have an unmet need for family planning. Furthermore, Obstetric Fistula is an ignored disability where around 3% of women have reported experiences of Obstetric Fistula, which constitute 29,461 women.[107] Access to obstetric fistula treatment services is very limited; only one national hospital has the capacity to manage complicated cases of Obstetric Fistula while two other regional hospitals have limited capacity to treat non-complicated cases.

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[102] United Nations Development Programme (UNDP). *Human Development Reports: Table 5: Gender Inequality Index*. Available: http://hdr.undp.org/en/composite/GII

[103] World Bank and United Nations. Pathways for Peace: Inclusive Approaches to Preventing Violent Conflict. Washington DC: World Bank. 2018

[104] World Health Organization. Trends in maternal mortality 2000 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. WHO:Geneva. 2019

[105] Bartlett LA, Mawji S, Whitehead S, et al. Where giving birth is a forecast of death: maternal mortality in four districts of Afghanistan, 1999–2002. Lancet 2005; 365: 864–70.

[106] Islamic Republic of Afghanistan. Ministry of Public Health & Royal Tropical Institute (KIT). *Afghanistan Health Survey 2018*. KIT:2018

[107] Central Statistics Organization (CSO), Ministry of Public Health (MoPH), and ICF. 2017. *Afghanistan Demographic and Health Survey 2015*. Kabul, Afghanistan: Central Statistics Organization.

Afghanistan remains a highly vulnerable country for natural and human-made disasters. In 2019, 6.3 million people needed humanitarian assistance, of which 4.5 million will be reached with assistance (0.5 million living in conflict-affected areas; 3 million affected by natural disasters; and 0.9 million people on the move).[108]

Returnee flows have accelerated since 2014 and are now reaching unprecedented levels. Nearly one million Afghans are thought to have returned to Afghanistan during 2016, mostly due to intensifying push factors in Pakistan. The total number of internally displaced is currently around 1.2 million. With push factors now playing the dominant role, there are concerns that returnees will have limited human capital, few resources, and limited connections to help manage the transition. Districts that have – on average – received more returnees since 2002 are likely to experience higher levels of conflict. This may reflect pressure on land and other resources generating conflict in the context of large returnee populations.[109]

UNFPA's 4th Country Program of Support to the Government of Islamic Republic of Afghanistan

The United Nations Population Fund (UNFPA), the 4th Country Program Document for Afghanistan (DP/FPA/CDP/AFG/4), approved by the Executive Board of the United Nations Population Fund. The initial CPD was for 2015-2019 which was extended to 2021. The CPD operationalizes the commitments outlined in the Country Program Development and contributes to the United Nations Development Assistance Framework (UNDAF) 2015-2019, which is jointly developed by UN agencies in Afghanistan in close partnership with, and the full leadership of, the Government of Afghanistan. The UNDAF responds to the vision and roadmap for achieving national development goals and aspirations as articulated through the Afghanistan National Development Strategy (ANDS). The program also contributes to the achievement of the Sustainable Development Goals (SDGs) by the Government of Afghanistan.

In 2016, the Islamic Republic of Afghanistan (GoIRA) launched the Afghanistan National Peace and Development Framework (ANPDF) to set the development vision of the country from 2017 to 2021. Consequently, as per the request of the Government, the UN developed the ONE-UN document for 2018-2021 is replacing the UNDAF to align the UN work with the national priorities as outlined in the ANPDF. The development of the ONE UN document 2018-2021 urged the UN agencies, including the UNFPA, to extend their CPD to align with the ONE UN document.

The 4th CP is designed to produce Seven Outputs, which contribute to the UNDAF and four UNFPA Strategic Plan outcomes. The summary and links between UNDAF, UNFPA Strategic Plan, and CP Outputs are described in the below table.

[108] United Nations. HUMANITARIAN RESPONSE PLAN 2018-2021

[109] The World Bank. Afghanistan to 2030: Priorities for Economic Development under fragility.

UNDAF Outcome	UNFPA Strategic Plan Outcome	CP Output	Government Partners	Implementing Partner
UNDAF Outcome 2: Basic Social Services: *All Afghans, especially the most marginalized and vulnerable, have equitable access to and use of quality health, nutrition, education, WASH, prevention and protection services that are appropriate and effectively address their rights and needs.*	***SP Outcome 1****: Increased availability and use of integrated 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.*	**Output 1**. Increased national institutional capacity to deliver a coordinated supply of modern contraceptives and improved quality of family planning services in selected provinces.	**MoPH**	**AFGA**
		Output 2. Increased national institutional capacity to deliver comprehensive maternal health services to underserved populations.	**MoPH**	**AFGA, AADA, MOVE, ACTD, AMA, Save the Children**
		Output 3. Increased national capacity to provide Reproductive health and GBV services in humanitarian settings.	**MoPH**	**ARCS, AADA, Health TPO**
	SP Outcome 2*: Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programs, particularly increased the availability of comprehensive sexuality education and Reproductive health.*	**Output 4.** Increased national capacity to conduct evidence-based advocacy for incorporating the rights and needs of adolescents and youth in national laws, policies and programs, in particular, healthy family life education and youth-friendly services	**MoPH, DMoYA, MoEd**	**AADA**

UNDAF Outcome	UNFPA Strategic Plan Outcome	CP Output	Government Partners	Implementing Partner
UNDAF Outcome 3: Social Equity and Investment in Human Capital: *Social equity of women, youth, minorities and vulnerable populations is increased through the Government's improved and consistent application of principles of inclusion in implementing existing and creating new policies and legislation.* ***UNDAF Outcome 4: Justice and Rule of Law:*** *Trust in and access to fair, effective, and accountable rule of law services is increased in accordance with applicable international human rights standards and the Government's legal obligations.*	***SP Outcome 3****: Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth.*	**Output 5**. Strengthened capacity of the health sector and law-enforcement bodies for prevention, response, and monitoring of GBV and child marriage in targeted provinces.	**MoPH, MoWA, MoI**	**IMC, Health Net-TPO, HEWAD**
UNDAF Outcome 5: Accountable Governance*: Improved legitimate, transparent and inclusive governance at all levels that enables progressive realization of human right*	***SP Outcome 4****: Strengthened national policies and international development agendas through the integration of evidence-based analysis on population dynamics and their links to sustainable development, Reproductive health and reproductive rights, HIV and gender equality.*	**Output 6.** Increased availability of national and local data, disaggregated by sex and age, used to formulate, implement and monitor policies and programs.	**NSIA**	**HEWAD,** IPEAD, International NGO
		Output 7. Increased capacity of government counterparts, parliamentarians, and academic institutions, in data utilization and advocacy for policy development, planning, and monitoring of programs	Ministry of Economy (MoEC) Kabul University (KU), and	**HEWAD,** IPEAD, International NGO

UNDAF Outcome	UNFPA Strategic Plan Outcome	CP Output	Government Partners	Implementing Partner
		on youth, gender equality and reproductive health.	Parliament	

The total projected budget of the 4th CP was USD 122 million (Regular Resource USD 32 million and Other Resources USD 50million) for 2015-2019 and USD 27 million (Regular Resource USD 7 million and Other Resource USD 22 million) for the extension period of 2020-2021. The key donors have been funding the UNFPA 4th CPD are: The United States Agency for International Development (USAID), Delegation of the Europen Union to Afghanistan (EU), International Development Bank (IDB), Global Affairs Canada (GAC), Italian Agency for Development Cooperation (IADC), United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA), Central Emergency Response Fund ''CERF'', UN World Food Programme (WFP), Australian Government, Department of International Development (DFID), Republic of Korea, United Nations Development Program and Republic of Japan.

UNFPA CO and the GoIRA represented by the Ministry of Economy (MoEC) signed the 4th Country Programme Action Plan (CPAP) to operationalize the 4th CPD. Both parties established a Program Steering Committee (PSC) as the highest governance body to oversee the implementation of CPAP and to provide strategic guidance. The PSC is lead by the MoEC with a membership consisting of Ministry of Public Health (MoPH), Ministry of Women Affairs (MoWA), Ministry of Interior (MoI), Deputy Ministry of Youth Affairs (DMoYA), and National Statistics and Information Authority (NSIA)/Central Statistics Organization (CSO). The PSC meets on an annual basis.

Most of the implementation modalities of the 4th CP and GoIRA/UNFPA Country Program Action Plan (CPAP) is through National Execution (NEX) where UNFPA works with Implementing Partners. This portion of activities are mostly at the sub-national level and varies from program to program; however, generally, the sub-national level activities are spread across 26 provinces of the country. Another component of the 4th CP and CPAP is implemented through Direct Execution (DEX) by UNFPA Country Office, especially about those activities where the Country Office has a comparative advantage and economies of scale. The DEX modality, UNFPA focuses on upstream work prioritizing policy, strategy, program, and capacity development, which are at the national level.

Objectives and Scope of Evaluation

The specific objectives of CPE include:

Provide an independent assessment of the relevance, effectiveness, efficiency, and sustainability of UNFPA support and progress towards the expected outputs and outcomes of the 4th CP in the changing development and humanitarian contexts;

Analyze expected, and unexpected results, challenges, and lessons learned of the CP4 implementation;

Provide an assessment of the CO's strategic positioning within the development community, including within the UNCT and national partners, and comparative advantage;

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

To review the design of the Country Programme including management, operations, coordination, and partnership arrangements;

The CPE will cover the period 2015 up to the end of 2019 and will include all initiatives under the four outcomes and seven outputs of the 4th CP. The CPE will cover all national and sub-

national level initiatives which were planned and/or implemented during the period 2015 to the end of 2019 in both development and humanitarian settings.

Evaluation Criteria and Preliminary Evaluation Questions

The evaluation of programmatic areas will follow the OECD DAC criteria of relevance, effectiveness, efficiency, and sustainability, and additional UNFPA specific criteria of coordination.

The evaluation team will select and further refine a maximum of ten evaluation questions in the design report:

Relevance

a. To what extent is UNFPA support in the fields of RH and rights, youth development, population and development, and gender equality (i) adapted to the needs of the population, particularly of the most vulnerable and marginalized, ii) adapted to priorities or shifts caused by crisis or major political change and (iii) in line with the priorities set by the national policy frameworks?

b. The CPE will also assess the alignment of Country Program (2015-2019 and its extension to 2021) with the UNFPA Strategic Plan 2018-2021 and One-UN Mutual Accountability Framework 2018-2021, and Sustainable Development Goals.

Effectiveness

a. To what extent have the 4th CP outputs been achieved, and to what extent have these outputs contributed to the achievement of the 4th CP outcomes?

b. To what extent has UNFPA responded to the RH and rights issues affecting pregnant and lactating women, young people, and women of reproductive age in general during the major humanitarian crises that occurred from 2015 to the present?

c. To what extent has UNFPA contributed to an improved humanitarian preparedness in Afghanistan in the areas of Reproductive Health (RH) and gender-based violence from 2015 to the present?

b. To what extent did the country program integrate a gender-responsive and human rights-based approach to program planning, implementation, and monitoring?

Sustainability

a. To what extent has UNFPA support helped to ensure that RH and rights, and the associated concerns for the needs of young people, gender equality, and relevant population dynamics are appropriately integrated into national development instruments and sector policy frameworks in the program country?

b. To what extent has UNFPA been able to support its partners and target populations in developing capacities and establishing mechanisms to ensure ownership and durability of effects of the 4th CP interventions?

c. To what extent has the CO established, maintained, and leveraged different types of partnerships to ensure that UNFPA can make use of its comparative strengths in the achievement of the country program outcomes across all programmatic areas?

Efficiency

a. To what extent has the CO made good use of its human, financial, technical and administrative resources, and has used an appropriate combination of tools and approaches to pursue the achievement of 4th CP outcomes promptly?

Coordination

a. To what extent has the UNFPA CO contributed to the functioning and consolidation of UN Country Team (UNCT) coordination mechanisms?

b. To what extent does the UNDAF/ One UN Program reflect the interests, priorities, and mandate of UNFPA in the country?

Added Value

a. What is the main UNFPA added value in the country context as perceived by national stakeholders?

Methodology and Approach

Evaluation approach

The evaluation team will use a multiple-method approach including (but not limited to) desk review of documents, data analysis and collection, analysis of some primary data and information through key informant interviews, group discussions, observations, and meetings with key partners. The theory of change used to design the 4th Country Programme will be reviewed and revised as necessary, based on stakeholder consultations to provide the basis for this evaluation.

The evaluation will be guided by the following standards, among others: Integrating Human Rights and Gender Equality in Evaluation, UNEG Norms, and Standards for Evaluation in the UN System, and UNEG Ethical Guidelines for Evaluation (http://www.unevaluation.org/document/detail/102). The evaluation will be transparent, inclusive, and participatory, as well as gender and human rights responsive. The evaluation will seek and utilize data disaggregated by age, gender, vulnerable groups, etc., to ensure findings that are gender reflective and targeted. The evaluation will use a mixed-method approach design as appropriate. Given the current challenges associated with the COVID 19 pandemic, data collection, stakeholder consultations/validations and dissemination of evaluation results may be conducted through remote/online platforms.

Stakeholder Participation: The evaluation will adopt an inclusive approach, involving a broad range of partners and stakeholders. Every effort will be made to include key stakeholders as part of the evaluation process either as sources of data (primary/secondary) or through their representation in the ERG. The evaluation team will refine and finalize the stakeholders mapping initially provided by the CO 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). These stakeholders may include representatives from the government, non-governmental organizations, the private sector, other UN and multilateral organizations, bilateral donors, and, most importantly, the beneficiaries of the program. Also, a CPE Reference group (ERG) will be established, which will include representatives from stakeholders, to provide quality assurance on the TOR, design report and the evaluation report.

Sampling strategy. The evaluation team will identify a suitable sampling strategy to reflect the large geographic coverage of 4th CP priority provinces, the wide range of stakeholders, including beneficiaries, the local COVID-19 context and the time available for data collection. The sampling strategy shall form part of the evaluation team's design report. UNFPA Afghanistan will provide necessary inputs such as priority programs, accessibility, and logistical support to

collect data. The purposive sampling of sites and stakeholders shall reflect the full range of 4th CP interventions in terms of themes and contexts (e.g. regular development programming, humanitarian response programming, work with indigenous populations.

Data collection

Primary data will be collected through semi-structured interviews, observations, and focus group discussions with policymakers, partners, and beneficiaries, as appropriate. Remote data collection methods will be utilized if the local COVID-19 context will not allow face-to-face data collection and travel within the country, including web-based or cell phone-based interviews and surveys with key stakeholder. A special attention will be given to identify feasible remote data collection methods to gather information from beneficiaries.

Secondary data will be collected through desk reviews of existing literature, policy and program documents, work plans, budgets, progress reports, databases, and various researches conducted by implementing partners.

Data triangulation

All evaluation findings should be supported with evidence. Data must be triangulated across sources and methods by cross-comparing the information obtained via each data-collection method (desk study, individual interviews, discussion groups) and double- or triple-checking the results of the data analysis. Evaluators should also cross-compare the evidence obtained through different data sources – e.g., compare evidence obtained through interviews with government staff with those obtained from beneficiaries or from secondary data sources.

Validation

The findings, conclusions and recommendations of the CPE will be validated with multiple stakeholders at different stages. At the end of the field data collection phase, the evaluation team will meet (physically or remotely) with UNFPA CO staff, and with Implementing Partners to share and discuss preliminary findings, conclusions and recommendations. Separate meetings with UNFPA staff and with Implementing Partners will be organized as the time permits in person or via online platforms.

A validation meeting with a wider group of stakeholders, not limited to Implementing Partners and ERG, will be conducted to discuss evaluation findings, conclusions and recommendations before the final report is submitted. This opportunity will allow integrating comments from stakeholders into the final evaluation report. ERG members will review draft reports and participate in validation meetings.

Evaluation audience

The UNFPA Country Office, UNFPA Regional and Head Quarters, Executive Board, the sector ministries, and subnational authorities of GoIRA, national and international CSOs, beneficiaries, UN agencies, and donors will be the key audiences of this CPE.

EVALUATION PROCESS

The evaluation will involve the following phases:

a. Preparation Phase

This is the first phase and done by the CO, which include the followings:

- ✓ Develop the ToR of the CPE, which is reviewed and endorsed by the Regional M&E Advisors and approved by the UNFPA Evaluation Office.
- ✓ Establish and orient the evaluation reference group
- ✓ Recruit the required evaluation team
- ✓ Inform the key stakeholders about the evaluation and preparation of documents.

b. Design Phase

This phase will include:

- ✓ A desk review of all relevant documents available at UNFPA HQ and CO levels regarding the country program for the period being examined (2015 up to end of 2019);
- ✓ Stakeholder mapping– the evaluation team, will prepare a map of stakeholders relevant to the evaluation and the strength of the relationship to the program. The map will cover state, civil society and other development actors, including UN sister agencies and bilateral donors;
- ✓ Reconstructing the intervention logic of the program – revisit the theory of change and results and resources framework meant to lead from planned activities to the intended results of the program;
- ✓ Developing the Evaluation Matrix: Finalize the list of evaluation questions, identify related assumptions and indicators to be assessed, and data sources (using the template and example provided in the UNFPA Country Program Evaluation Handbook);
- ✓ Developing data collection, sampling, and analysis strategy;
- ✓ Specifying limitations and risks in conducting the evaluation and plan mitigation strategies to overcome these limitations and risks.
- ✓ Developing a concrete work plan for the field phase along with clear delineation of the roles and responsibilities of team members; and
- ✓ Finalizing the design report. A design report will be produced in accordance with the UNFPA CPE Guidance that is quality assured by the Evaluation Reference Group (ERG)and approved by the UNFPA Regional M&E Advisor before commencing the field phase.

b. Field Phase

In this phase, the Evaluation Team will conduct a 4-week in-country field mission to collect the data and conduct preliminary analyses required to answer the evaluation questions. If the face-to-face missions and meetings cannot take place due to COVID_19, remote data collection methods will be used by the Evaluation Team. The Team Leader will be engaged in data collection remotely due to restrictions to international travel. At the end of the data collection, the team will conduct a face-to-face or online debriefing meeting(s) with UNFPA CO, IPs and ERG to present the preliminary findings and test preliminary conclusions and recommendations.

c. Reporting Phase

During this phase, the evaluation team will continue the analytical work initiated during the field phase and prepares a first draft of the evaluation report, taking into account the comments made by the CO and IPs at the validation workshop. The draft evaluation report will be submitted to UNFPA CO and the ERG for formal review and comments. The comments from the UNFPA CO and ERG comments will be addressed by the evaluation team in revising the draft final report with an audit trail of response to comments provided.

The country office will convene a dissemination workshop (either face-to-face or online) attended by the CO as well as key program stakeholders (including key national counterparts, donors, CSOs representing beneficiaries) to share the findings, conclusions, and recommendations of the Report. This workshop will provide an opportunity to validate the factual content of

the report and broaden the ownership of the evaluation findings and way forward. The evaluation team will finalize the CPE report, working closely with the UNFPA CO and ERG, based on the feedback from this workshop.

The final report will be cleared by the CO and submitted to the Regional M&E Advisor for approval. The quality of the report will be assessed based on the criteria set out in the CPE Guidance (see Annex 6 for details). Once accepted, the Regional M&E Advisor will submit draft EQA (along with the Report) to EO for finalization of the quality assessment of the CPE.

d. Management Response, Dissemination and Follow Up

The management of the CO will provide a management response to each evaluation recommendation. Asia and Pacific Regional Office (APRO) will quality assure the response. The final response will be uploaded in the corporate tracking system within six weeks of the finalization of EQA and communication by EO. The CO will be responsible for periodically updating the status of implementing the management response. The CO senior management will be responsible for ensuring that the lessons and evidence emerging from the CPE fully informs the design of the 5th CP.

A dissemination strategy will be in place to share findings and lessons internally within UNFPA and externally. The evaluation report will be posted on the CO website and the evaluation database (together with the evaluation quality assessment document) maintained by the HQ EO. The findings will be shared with partners and the public through public websites, national and international meetings, conferences, journals, and media briefs, as per the dissemination strategy.

EXPECTED OUTPUT AND DELIVERABLES

The evaluation team will produce the following deliverables:

a. **The design report** (following the attached outline) including (as a minimum):

- Stakeholder map;
- Evaluation Matrix (including the final list of evaluation questions and indicators);
- Overall evaluation design and methodology, including a detailed description of the data collection plan for the field phase;
- Roles and responsibilities of the team members and a work plan;

b. **The debriefing presentation** document synthesizing the main preliminary findings, conclusions, and recommendations of the evaluation, to be presented and discussed with the CO, IPs, and ERG during the debriefing meeting foreseen at the end of the field phase;

c. **The draft evaluation report, with Annexes** (followed by a second draft, taking into account potential comments from the UNFPA CO and evaluation reference group);

d. **A presentation of the results of the evaluation** for the dissemination workshop;
e. A final report, based on comments expressed during the dissemination workshop, and

f. **An Evaluation Brief**, a two-page summary of key evaluation findings/ conclusions/ recommendations of the final CPE report.

All deliverables will be drafted in English and shall follow the structure and detailed outlines in the Handbook on How to Design and Conduct a Country Program Evaluation at UNFPA.

Workplan and Indicative Schedule of Deliverables

Phases	Activity/ Milestone	Timeframe												Responsible Unit
		July-Dec 2020	July 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	March 2021	April 2021	May2021	
Preparation Phase	Establish ERG Drafting the ToR by the CO, review by ERG, APRO M&E Advisor, and approval by the UNFPA HQ - Recruitment of consultants and vetting of the ET by EO - Preparation of documents													CO: Assist Rep APRO: Regional M&E Advisor HQ: Evaluation Advisor for AP
Design	Pre-evaluation briefings with the Evaluation Team (ET) on 4th CPE expectations and requirements - Presentation by Evaluation Manager (EM), National Program Officers, International Operations Manager		Wk 1											CO Program Team, CO Operations Team, Eval'n Manager (EM), ET
	Desk review of secondary data and information for the development of the CPE Design Report		Wks 1-4	Wk 1										ET
	Draft and submit CPE Design Report to the CO/Evaluation Reference Group (ERG)			Wk 1										ET

	Review and comment by ERG			Wk 2-3										
	Finalize the design report for APRO's review			Wk 4										
	Approval of the Design Report by APRO (including data collection tools and fieldwork plan)			Wk 4										ERG, EM, UNFPA CO, ET
Field	Data collection from partners/ stakeholders and those from sampled 4th CP provinces, including preliminary analysis				Wks 4									ET
	Debrief at the CO including the IPs and ERG				Wk 4									ET
Reporting	Continuation of analytical work initiated during the field phase				Wk 4	Wks 1-2								ET
	Preparation and submission of first draft evaluation report					Wks 3-4								ET
	Quality assurance of the first evaluation draft report by the ERG, CO, and APRO M&E Adviser						Wks 1-2							ERG, EM, UNFPA CO, APRO M&E Advisor
	Preparation and submission of the second draft evaluation report							Wks 3-4						ET

	Dissemination workshop								Wk 1					
	Preparation and submission of the final evaluation report								Wk 3-4					ET
	Clearance of the report by APRO M&E Advisor and EQA draft submission to EO (3 weeks)									Wks 2-3				
	EO finalization of EQA (4 weeks)											Wk 2		
	Develop and submit the CO Management Response to the CPE report												Nov 2020-May 2021	CO Senior Management Team
Dissemination Phase	Integrate recommendations into the new CPD. Dissemination of findings to wider stakeholders											Wks 3-4	Wks1-4 Nov 2020 –May 2021	ET, UNFPA CO, ERG, EM

COMPOSITION, ROLES, AND QUALIFICATION OF THE EVALUATION TEAM

The evaluation will be conducted by an independent multi-disciplinary evaluation team composed of an International Consultant/Evaluation Team Leader and three National Evaluation Consultants.

The **Evaluation Team Leader** will have the overall responsibility during all phases of the evaluation to ensure the timely completion and high quality of the evaluation processes, methodologies, and outputs. In close collaboration with national evaluators, she/he will lead from distance the design of the evaluation, guide the methodology and application of the data collection instruments, and lead the consultations with stakeholders. At the reporting phase, she/he is responsible for putting together the draft evaluation report, based on inputs from other evaluation team members, and in finalizing the report based on inputs from the ERG and stakeholders. To complement the assessment of the program components, she/he will also assess the operational (e.g., financial, administration, procurement) and monitoring and evaluation systems of the CO in both regular development and humanitarian settings.

In addition to the overall responsibility of the CPE, the evaluation team leader is expected to cover the **Population and Development** component of the CPE as well. The evaluation team leader will be responsible for assessing the population and development thematic area of the 4th CP (e.g., collection and socio-demographic analysis data, evidence-based policy advocacy, national capacity development in evidence-based planning, monitoring and evaluation, analysis of population dynamics and their interlinkages with other sectors, strengthening of national statistical systems, etc.), including the use of population data in humanitarian situations. She/he will take part in the data collection and analysis work during the design and field phases assisted by a team of national consultants as needed, and shall be responsible for drafting key parts of the design report and of the final evaluation report, including (but not limited to) sections relating to population and development.

Qualifications, Experience, and Competencies of the Evaluation Team Leader (International Consultant)

- ✓ An advanced degree in social sciences, population studies, political science, economics, statistics, program management, monitoring, and evaluation, or related fields;
- ✓ Significant knowledge of and professional experience (minimum ten years) in complex evaluations in the field of development aid for UN agencies and/or other international organizations;
- ✓ Should have demonstrable experience in leading multi-cultural, multi-disciplinary evaluation teams; and familiarity with the region in general, and Afghanistan, in particular, is essential;
- ✓ Substantive knowledge and experience in population and development;
- ✓ Familiarity with UNFPA or UN mandates and operations is necessary;
- ✓ Excellent management skills and ability to work with multi-disciplinary and multi-cultural teams;
- ✓ Excellent analytical, communication, and reporting skills; and
- ✓ Fluency in English.
- ✓ Substantive knowledge and experience in the humanitarian program is desirable;

The three national evaluation consultants will cover the following areas of expertise:

The **Reproductive Health Specialist** will primarily be responsible for assessing the RHR (including maternal health, family planning, health sector response to GBV) thematic area of the 4th CP in both regular development and humanitarian settings. She/he will take part in the data collection and analysis work during the design and field phases, and shall be responsible for drafting

key parts of the design report and of the final evaluation report, including (but not limited to) sections relating to RH and rights.

Qualifications, Experience, and Competencies of the Reproductive Health Specialist

- ✓ An advanced degree in public health,
- ✓ Substantive knowledge of and professional experience (minimum 7-10 years) in reproductive health, including themes/issues relevant to maternal health, family planning, ARH, health sector response to GBV, HIV/AIDS, cross-cutting themes such as youth and gender, and health systems in general;
- ✓ Significant knowledge and experience in complex evaluations in the field of development aid for UN agencies and/or other international organizations;
- ✓ Good knowledge of the national development context and fluency in English and Dari/Pasho (knowledge of other major dialects would be an advantage);
- ✓ Familiarity with UNFPA or UN mandates and operations will be an advantage;
- ✓ Strong interpersonal skills and ability to work with multi-cultural, multi-disciplinary teams;
- ✓ Proven drafting skills in English; and
- ✓ Ability to work in a team.
- ✓ Substantive knowledge and experience in the humanitarian program is desirable

The **Adolescent and Youth Specialist** will primarily be responsible for assessing the adolescent and youth thematic area of the 4th CP (e.g., youth health line, youth health corner, school health, family life education, youth parliament, demographic dividend, youth policy advocacy and coordination). She/he will take part in the data collection and analysis work during the design and field phases, and shall be responsible for drafting key parts of the design report and of the final evaluation report, including (but not limited to) sections relating to adolescent and youth.

Qualifications, Experience, and Competencies of the Adolescent and Youth Specialist

- ✓ An advanced degree in public health, education, demography, social sciences, or related fields;
- ✓ Substantive knowledge of and professional experience (minimum 5 years) in adolescent and youth programme, including youth programme evaluation.
- ✓ Significant knowledge and experience in complex evaluations in the field of development aid for UN agencies and/or other international organizations;
- ✓ Good knowledge of the national development context and fluency in English and Dari/Pashto (knowledge of other major dialects would be an advantage);
- ✓ Familiarity with UNFPA or UN mandates and operations will be an advantage;
- ✓ Strong interpersonal skills and ability to work with multi-cultural, multi-disciplinary teams;
- ✓ Proven drafting skills in English; and
- ✓ Ability to work in a team.

The **Gender Equality Specialist** will primarily be responsible for assessing the gender equality thematic area of the 4th CP (e.g., women's human rights and reproductive rights, gender and development, prevention of discrimination, prevention and response to gender-based violence, child marriage), including GBV prevention and response in humanitarian situations. She/he will take part in the data collection and analysis work during the design and field phases, and shall be responsible for drafting key parts of the design report and of the final evaluation report, including (but not limited to) sections relating to gender equality.

Qualifications, Experience, and Competencies of the Gender Equality Specialist

- ✓ An advanced degree in women/gender studies, social sciences or related fields;
- ✓ Substantive knowledge of and professional experience (minimum 7-10 years) in gender

equality, including themes/issues relevant to women's human rights and reproductive rights, gender and development, prevention of discrimination, prevention and response to gender-based violence and child marriage, etc., and cross-cutting themes such as youth;
- ✓ Significant knowledge and experience of complex evaluations in the field of development aid for UN agencies and/or other international organizations;
- ✓ Good knowledge of the national development context and fluency in English and Dari/Pashto (knowledge of other major dialects would be an advantage);
- ✓ Familiarity with UNFPA or UN mandates and operations will be an advantage;
- ✓ Strong interpersonal skills and ability to work with multi-cultural, multi-disciplinary teams;
- ✓ Proven drafting skills in English; and
- ✓ Ability to work in a team.

Indicative Allocation of Working Days per Evaluation Team Member:

Evaluation Team Member	Design Phase (Weeks	Field Phase (Weeks 5-11)	Reporting Phase (Weeks 11-24)	Total Person-Days Re-
Team Leader	16	24	30	70
RH Specialist	1	22	15	51
A&Y Specialist	1	22	15	51
Gender Specialist	1	22	15	51

REMUNERATION AND DURATION OF CONTRACT

Guided by Sections 9 and 10 above, workdays will be distributed between the date of signature and the approval of the submitted final report. In addition to consultancy fees, travel costs will be paid as per UNFPA Travel policy.
The following payment scheme will be applied:

- Upon receipt of the approved design report: 20%
- Upon completion of the field phase: 10%
- Upon receipt of the second draft evaluation report: 30%
- Upon receipt of the approved final evaluation report and evaluation brief: 40%

Management of the Evaluation

The CO Assistant Representative will serve as **UNFP A's Evaluation Manager** and will:

- ✓ Lead the development of the CPE ToR and the preparation of the management response to the evaluation;
- ✓ Facilitate access to background documents and key informants during data gathering;
- ✓ Coordinate the quality assurance process for the evaluation products and processes: ToR, Design Report, Evaluation Report, sampling strategy, validation methods, etc.;
- ✓ Serve as the CO focal point for APRO, EO
- ✓ Coordinate and convene the ERG meetings/inputs to the evaluation;
- ✓ Manage the evaluation budget;
- ✓ Ensure logistical and administrative support to the evaluation team;
- ✓ Upload on a semi-annual basis the implementation status of management response.

Evaluation of team roles and responsibilities

The evaluation team's role and responsibilities are to design the evaluation, conduct the field data collection, analysis, and developing the report of the evaluation. The details are described under the Evaluation Process presented above.

The Evaluation Manager will be assisted by the Evaluation Reference Group(ERG) in assuring the quality of the evaluation.

This group comprises of an external group of stakeholders (national government, civil society, multilateral and bilateral donors, sister UN agencies and UNFPA APRO M&E Advisor) and will consist of the following members, subject to confirmation and availability:

1. General Director of Policy and Planning and Result Based Management, Ministry of Economy (MoEC)
2. General Director of Policy and Planning, Ministry of Public Health (MoPH)
3. Deputy Director, National Statistic and Information Authority (NSIA)
4. General Director of Policy and Planning, Ministry of Women Affairs (MoWA)
5. Programme Director, AADA, Representative of Civil Society Organizations (CSOs)
6. Senior Development Officer, GAC, a representative of Donors
7. Regional M&E Advisor, APRO UNFPA

The ERG is expected to participate in the virtual meeting and written feedback during the evaluation and has the following specific responsibilities:

- Provide inputs to the ToR and assure quality;
- Support the evaluation team in accessing key informants, documents, mapping stakeholders, etc. as needed;
- Feedback on the design and draft evaluation reports; and
- Broaden the ownership of the evaluation and facilitate broader dissemination of the findings.

The CO Evaluation Manager will be the convener of the ERG and will coordinate and facilitate communications between the evaluation team and the ERG. The ERG team will meet where feasible and needed to discuss the ToR of the evaluation, the design report, and debriefing after the evaluation fieldwork. Other consultations or requests for inputs from the ERG will be through e-mail communications.

The**UNFPA APRO M&E Adviser** will provide guidance and quality assurance as needed throughout the evaluation process and will be responsible for clearing the ToR for EO's approval, and reviewing and approving the design report and the final evaluation report, and drafting the EQA for subsequent submission to EO.

The **UNFPA Evaluation Office** will approve the final ToR as well as endorse the evaluation team. The EO will provide the final Evaluation Quality Assessment of the CPE.

The **UNFPA CO** will provide the necessary documents and reports and refer the team to web-based material or relevant official databases. The CO management and staff will make themselves available for interviews and provide technical assistance, as appropriate. The CO will provide necessary logistical support in terms of providing spaces for the meetings, assist in making the appointments and arranging travels, and site visits when necessary. The CO will assist the evaluation team in preparing and facilitating discussions at the field level. The use of office space will be provided as needed.

Bibliography

1) Handbook on How to Design and Conduct a Country Program Evaluation at UNFPA: https://www.unfpa.org/EvaluationHandbook
2) OECD-DAC Evaluation Criteria: https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm
3) Afghanistan Parliament: http://www.parliament.af/
4) Ministry of Foreign Affair Afghanistan: https://www.mfa.gov.af/
5) Ministry of Public Health Afghanistan: https://moph.gov.af/en
6) Ministry of Economy Afghanistan: https://moec.gov.af/
7) Ministry of Women Affairs Afghanistan: https://mowa.gov.af/en
8) Ministry of Education Afghanistan: https://moe.gov.af/en
9) Deputy Ministry of Youth Affairs: https://moic.gov.af/en
10) Kabul University: http://ku.edu.af/en
11) Afghanistan Independent Human Rights Commission: https://www.aihrc.org.af/home/press_release/6865
12) Government National Data, MDG progress reports, and data: https://nsia.gov.af/library
13) Afghanistan SDGs: https://sdgs.gov.af/
14) Afghanistan National Prioritz Programs: http://policymof.gov.af/home/national-priority-programs/the-new-npps/
15) United Nations Population Fund Afghanistan: https://afghanistan.unfpa.org/
16) United Nations Assistance Mission in Afghanistan: https://unama.unmissions.org/
17) Afghanistan UNDAF 2015-2019
18) Afghanistan ONE-UN 2018-202: https://www.af.one.un.org/en/
19) UNFPA Strategic Plan 2018-2021: https://www.unfpa.org/strategic-plan-2018-2021
20) Standard Basic Assistance Agreement between the Islamic Republic of Afghanistan and the United Nations Population Fund (SBAA)
21) UNFPA Afghanistan 4th CPD (2015-2019) and Extension 2020-2021
22) UNFPA Afghanistan and GoIRA Country Program Action Plan (CPAP-2015 – 2019)
23) UNFPA Afghanistan 4th CPD Program Steering Committee Documents (ToR and Minute of Program Steering Committee of the 4th CPAP)
24) MoUs with government partners and annual action plans
25) Donors reports
26) Annual Work Plans of Direct Execution (DEX) and National Execution (NEX)
27) CPAP M&E Framework and tools
28) The Country Office Resource Mobilization Strategy for implementation of the 4th CPAP
29) CO proposals and donor agreements
30) Implementing partners Work Plan Progress Reports
31) Existing and upcoming CO research and evaluations and project implementation reports such as Annual Work Plans, Work Plan Progress Reports, and Annual Work Plan Review and Planning Report

Annexes

Annex 1: Theory of Change
Annex 2: 4th CP Results and Resources Framework 2015-2019
Annex 3: 4th CP Extension Result Framework 2020-2021
Annex 4: Ethical Code of Conduct for UNEG/UNFPA Evaluations
Annex 5: Evaluation Matrix template
Annex 6: Outline of the Design Report
Annex 7: Outline of the Final Evaluation Report
Annex 8: Evaluation Quality Assessment (EQA) Grid
Annex 9: Specific Items to be included in the Technical and Financial Bids
Annex 10: Management response template
Annex 11: United Nations-Approved editing guidelines
Annex 12: The Stakeholder Map
Annex 13: List of ATLAS Projects by Country Program Output and Strategic Plan Outcome

Annex 2: List of Participants Interviewed

Name of person Interviewed for KII	Title	Organization/ Ministry/ Agency
Implementing Partners		
Dr. Najeeb Baleegh,	Director of Programmes	AADA
Dr. Abdul Qadeer,	Senior Programme Manager	AADA
Dr. Farhat Sahak, senior	Programme Manager	AADA
Dr. Rasool, UNFPA NTA	NTA, Youth And Adolescent	AADA
Wazhma Habibi,	Focal Point, Health Corner	AADA
Getti Saduzai	Executive Director	AMA
Noria Omidi,	Project Focal Point	AMA
Zahra Mirzaee,	President	AMA
Dr. Younus Alikhil,	Programme Coordinator	ARCS
Dr. Attaullah Mahmoodzai,	Emergency Manager – Public Health	ARCS
Dr. Maruf Laizada	Programme Officer	HEWAD
Dr. Najibullah Ali Zoi,	Programme Director,	Health Net TPO
Dr. Hazrat Amin,	Project Manager,	Health Net TPO
Jamila Shahidani	M&E Officer	Health Net TPO
Dr. Ahmad Jawed,	GBV Programme Coordinator,	IMC
Ms. Farishta, Andaravi	GBV M&E and Training Officer	IMC
Naikmal Shah	CEO / Programme Director	AFGA
Rafiullah Saidy	Project Focal Point	AFGA
Taiba Jafara	Programme support coordinator – NTA	AFGA
Amir Hamza Aslami	Dean of Faculty – Student – Scholarship in Demography	Kabul University
Shahab Jawab	Previous Coordinator of UNFPA – PhD Student	Kabul University
Jamshed Haidery	Coordinator for UNFPA, Dept. of Statistics and Demography	Kabul University
Habibullah Niazi	Stats and Demo Department – Student of PhD	Kabul University
Dr. Homayoon Popal,	Programme Manager	MOVE
Mr. Siar Akbar,	Finance Manager	MOVE
Mohamed Sharafat	M&E Technical Manager	MOVE
Sultani Latifa	Women's Rights Commissioner	HUMAN Rights Commission
Salma Alokozai	Consultant	HUMAN Rights Commission
	Malalai Hospital Kabul [Beneficiary institution]	Chief of Ward, OF
Dr Shakila Sina	Herat Hospital [Beneficiary institution]	Trainer Specialist, OF
Jamila Thamkin	Herat Hospital [Beneficiary institution]	Trainer Specialist, OF
Sub-Cluster Co-Leads		
Vicki Aken	CD of Afghanistan	IRC [SC – Co-Lead]
Leisha Beardmore	Snr. Protection Coordinator / GBV Co-Lead	IRC [SC – Co-Lead]
Liser Piper	Director	ACBAR [SC – Co-Lead]
Mohamed Jawed	Operations Director	YHDO [SC – Co-Lead]

Shafiullah Safi	M&E Manager/ GBV Sub-Cluster Co-Coordinator	YHDO [SC – Co-Lead]
Strategic Partners (Government Ministries and Agencies)		
Layeq Shah Zadran, ,	Deputy Minister	DMoYA
Hazratullah Sharifi,	Director Of Coordination	DMoYA
Mohamad Hanif Ahmadzai,	Capacity Building Officer	DMoYA
Mr. Suhrab Bahman,	Economic Advisor And Spokesman	MoEC
Atal Gardiwal,	Programme Director,	NSIA
Mohamad Samim Abi,	Survey Deign Specialist	NSIA
Ahmad Khalid Amarkhil,	Data Quality Specialist	NSIA
Sahrifa Arman	Data Collection Officer,	MoPH, Gender
Marzia Naderi,	M&E Officer,	MoPH, Gender
Nafisa Kohestoni	M&E Director	MoWA
Mary Sadat	Director of Policy and Planning	MoWA
Nizamudding Adil,	Director of IPUR	Parliament Forum
Hamidullah Zazai	Snr Advisor to the Secretary General of Wolesi Jirga	Parliament Forum
Idriss	Coordinator for UNFPA Programme	Parliament Forum
Mowlawi Usman Tariq,	Deputy Minister Policy And Planning	MoHRA
Nasir Ahmadi,	Director Of Policy And Planning	MoHRA
Ms. Malika Mahira:	Director Of Female Educations Directorate	MoHRA
Ms. Marwa Amini, ,	Director, Human Rights And Women Affairs	MoI
Dr. Ghotai yaqobi,	Acting RMNCH Director	MoPH, RMNCH
UN Agencies		
Alim Atarud	Deputy PM for Global Programme – TB/HIV	UNDP
Parvathy Ramaswami	Humanitarian Coordinator & Deputy CD - Programme	WFP
Ramiz Alakbarov	UN Resident Coordinator	UN Mission – Afghanistan
Dr. Najib Safi,	Programme Director, Health System	WHO
Aye Aye Than	Youth and Adolescent Specialist	UNICEF
Veronica Kamanga Njikho	Gender Programme Specialist	UNICEF
Alison Miriam DAVIDIAN	Deputy Representative	UN Women
Zohra Jalal	Head of Humanitarian Unit	UN Women
UNFPA		
Koffi Kouame	Country Representative	UNFPA
Kwabena Asante-Ntiamoah	Deputy County Representative	UNFPA
Dr. Noor Murad	Adolescent and Youth Programme Specialist	UNFPA
Ms. Baseera Mayar	Programme Assistant, Adolescent and Youth	UNFPA
Dr. Abdul Qader Raza,	Programme Specialist – Humanitarian Assistance	UNFPA
Dr. Zarbadsha Jabarkhil,	Programme Officer - Humanitarian Assistance	UNFPA
Dr. Ahmad Murid Haidary,	Bamian Provincial Coordinator, RHR	UNFPA
Dr. Ahmadullah Mulakhil,	RH Specialist	UNFPA
Najibullah Baryal,	Herat Provincial Coordinator, RHR	UNFPA
Abdu Malik Faizi	Programme Officer, RH	UNFPA
Khalid Sharifi,	Assistant Country Representative	UNFPA

Abdul Aziz Frotan,	Planning, Monitoring and Evaluation Officer	UNFPA
Ms. Sulaf Mustafa	Gender Programme Specialist	UNFPA
Farangies shah	GBV Health Analyst	UNFPA
Abibullah Wahidi	Programme Assistant	UNFPA
Homa Habib	Gender Programme Analyst	UNFPA
Mohamed Niaz	GBV Coordination	UNFPA
Ahmad Roin Safi	Programme and Finance Associate	UNFPA
Dr. Bashir Najeeb	Programme Specialist, PD	UNFPA
Abdul Jalil Kamawi	Programme Assistant	UNFPA
Ayurzana Bayaraa	Operations Manager	UNFPA
Hamed Rabbani	Procurement Focal Point	UNFPA
Ahmad Gul Farid	Admin and Logistics	UNFPA
Tahmina Imadi	HR Focal Point	UNFPA
Donor Agencies		
Nasir Ebrahimkhail	Senior Programme Officer – Health–	Canadian Embassy
	Humanitarian and Anti-Corruption Focus – Health Sector – ODA	Canadian Embassy
Rose Roxburgh	Secretary	Australian Embassy
Ahmad Shah Imam		Australian Embassy
Naseer Malikzai	Senior Programme Manager – Gender	Australian Embassy
Leslie ODonoghue	Director of Humanitarian	Australian Embassy
Alison McLachlan	Policy Officer – Gender Equality	Australian Embassy
Morine Nielsen	Gender and Agriculture Programme Advisor	Australian Embassy
FGDs participants (Beneficiaries)		
Ismail Sherzai	Member	Youth Parliament
Iqbal Sakhi	Member	Youth Parliament
Rabia Ahmadi	Member	Youth Parliament
Syed Kabir Hussainy	Member	Youth Parliament
Aga Mohamad Quraishi	Member	Youth Parliament
Sadat Khan	Member	Youth Parliament
Dr. Farib Seddiqi	Counsellor, YHC	Gozara DH, Hirat
Muzhgan Sami Zada	Counsellor, YHC	Gozara DH, Hirat
Dr. Syed mashooq Sadat	Counsellor, YHC	Gozara DH, Hirat
Karima Habibi	Counsellor, YHC	Gozara DH, Hirat
Dr. Enayath Mohamadi	CHC-In-Charge And YHC Doctor, YHC	Mirzaman Khan CHC, Kandahar
Dr. Fida Mohamad Sahar	Youth Health Officer, PHO	Mirzaman Khan CHC, Kandahar
Miss. Rana	Midwife, YHC	Mirzaman Khan CHC, Kandahar
Miss Shukria	Psycho Social Counsellor, YHC	Mirzaman Khan CHC, Kandahar
Mohamad Danish	Psychosocial Counsellor	Bamyan Provincial hospital
Khadija Mosawi	Psychosocial Counsellor	Bamyan Provincial hospital
Najibullah	Nurse	Bamyan Provincial hospital
Safia	Midwife	Bamyan Provincial hospital
Zarina	Health Educator	Bamyan Provincial hospital

Dr. Barishna	Female Doctor	Khiwa CHC, Nangarhar
Kaenat, from Khiwa CHC	Midwife	Khiwa CHC, Nangarhar
Jalath Khan	Nurse	Khiwa CHC, Nangarhar
Dr. Ataullah, from Khiwa CHC	Male Doctor	Khiwa CHC, Nangarhar
Dr. Farkhonda Azimi, Y&A Officer,	Health Educator	Kisham DH, Badakhshan
Mr. Zamanuddin	Psychosocial Counsellor	Kisham DH, Badakhshan
Dr. Ataullah	Children Specialist	Kisham DH, Badakhshan
Ms. Nilofar	Female Nurse	Kisham DH, Badakhshan
Ms. Nasima	Midwife	Kisham DH, Badakhshan
Dr. Wahidullah Nori	YHL counsellor	Kabul YHL
Dr. Rana Sofia	YHL counsellor	Kabul YHL
Dr. Balgis Umar	YHL counsellor	Kabul YHL
Dr. Mariam Mirzaee	YHL counsellor	Kabul YHL
Dr. Humaira	YHL counsellor	Kabul YHL
Dr. Shah Mohmood	YHL counsellor	Kabul YHL
Dr. Basit Maeil	YHL counsellor	Kabul YHL
Ms Asmaan	MHT Laghman	Midwife
Ms Laila	FHH Faryab, Qaisar	Midwife
Ms Rakia	FHH Faryab, Pashtoon Kot	Midwife
Ms Hanifa	FHH Faryab, Dawlat Abad	Midwife
Ms Zarefa	FHH Faryab, Kohistan	Midwife
Ms Amina	FHH Herat, Chishte Sharif	Midwife

Annex 3: Documents Consulted

1. Country Programme document (the most recent)
2. 2015 Annual Report - Afghanistan SIS
3. 2016 Annual Report - Afghanistan SIS
4. 2017 Annual Report - Afghanistan SIS
5. 2018 Annual Report - Afghanistan SIS
6. 2019 Annual Report - Afghanistan SIS
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48. Investing in Youth: How to Realize Afghanistan's Demographic Dividend, UNFPA 2015
49. Midterm Review of the DFAT Ending Violence Against Women (EVAW) Program in Afghanistan – Adam Smith International (2016)

Annex 4: Atlas Projects

Year N		Year N+1		Year N+2

Fund Type	IA group	Implementing Agency	Activity Description	Geographic Location	ATLAS budget	Expense	Implementation Rate
REPRODUCTIVE HEALTH							
Strategic plan outcome: (descriptions as per CPD): **SP Outcome 1:** Increased availability and use of integrated 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. **SP Outcome 2:** Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased the availability of comprehensive sexuality education and Reproductive health. **UNDAF Outcome 2:** Basic Social Services: All Afghans, especially the most marginalized and vulnerable, have equitable access to and use of quality health, nutrition, education, WASH, prevention and protection services that are appropriate and effectively address their rights and needs.							

Country Programme Output: **Output 1:** Increased national institutional capacity to deliver a coordinated supply of modern contraceptives and improved quality of family planning services in selected provinces							
Annual work plan (code and name)							
USA40 (USAID)		Activity 01	Generating Strategic Information on Family Planning in Afghanistan	Kabul	193,598.95	140,129.94	72%
EUB06 (EU)		Activity 01	Increasing the use of modern contreception prevelance rate (mCPR), Increased demand for family planning services, Improved male involvement in FP services and increased FP knowledge of adolecents and young people	Nangarhar, Laghman, Kunar, Samangan, and Badakhshan	388,315.00	372,038.00	96%
FPA90		Activity 01	Reproductive, maternal, newborn and child and adolescent (RMNCAH) health services through FHHs to women and children in Faryab provinces. Support to Nangarhar Obstetric Fistula Ward and OF Patients immediate Expenditures in Nangarhar	Faryab, Harat, Nangarhar	2,045,797.51	1,921,698.86	94%
Strategic plan outcome: (descriptions as per CPD): **SP Outcome 1**: Increased availability and use of integrated 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. **SP Outcome 2:** Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased the availability of comprehensive sexuality education and Reproductive health. **UNDAF Outcome 2:** Basic Social Services: All Afghans, especially the most marginalized and vulnerable, have equitable access to and use of quality health, nutrition, education, WASH, prevention and protection services that are appropriate and effectively address their rights and needs.							
Country Programme **Output2:** Increased national institutional capacity to deliver comprehensive maternal health services to underserved populations							
Annual work plan (code and name)							
AFG01 (IDB)		Activity 01	Establishing Comprehensive Obstetric Fistula Program in Afghanistan	Kabul	105,181.00	92,282.78	88%

CAA36 (Canada)		Activity 01	"Family Health Houses in Daikundi Province	Daikundi	4,557,263.65	4,557,263.63	100%
ITA15 (Italy)		Activity 01	Improving Reproductive Health and Promoting Women's Empowerment' in Herat Province through FHHs in Herat	Herat	599,174.90	548,691.90	92%
ITA29 (Italy)		Activity 01	Improving Reproductive Health and Promoting Women's Empowerment in Herat and Ghor Provinces	Herat and Ghor	1,856,683.00	1,308,402.91	70%
CAA67 (Canada)		Activity 01	"Providing Essential Reproductive, Maternal, Newborn and Child Health(RMNCH) Services and Promoting Women's Empowerment through Family Health Houses"	Kandahar, Samangan, Nooristan, Badghis, Paktika and Daikundi	3,412,436.00	2,140,520.00	63%
FPA90		Activity 01	Providing OF services in Malalai obstetric fistula ward	Kabul	8,372,771.60	7,923,187.30	95%
Strategic plan outcome: (descriptions as per CPD): **SP Outcome 1:** Increased availability and use of integrated 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. **SP Outcome 2:** Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased the availability of comprehensive sexuality education and Reproductive health. **UNDAF Outcome 2:** Basic Social Services: All Afghans, especially the most marginalized and vulnerable, have equitable access to and use of quality health, nutrition, education, WASH, prevention and protection services that are appropriate and effectively address their rights and needs.							
Country Programme **Output3**: Increased national capacity to provide Reproductive health services in humanitarian settings							
Annual work plan (code and name)							
HFA25 (UNOCHA)		Activity 01	Increased access by pregnant women and women of reproductive age to emergency obstetric and newborn care services	Helmand, Paktia, Paktika, Khost, Daikundi, Bamyan,	93106.91	88906	95.49 %

				Badakhshan and Nimroz			
UOE53 (Central Emergency Response Fund "CERF")		Activity 01	Providing reproductive health services to women of childbearing age	Khost and Paktika	155902.02	155979.02	100.05%
UOF06 (Central Emergency Response Fund "CERF")		Activity 01	Providing reproductive health services to women of childbearing age	Kunar and Nuristan	240057.47	163695	68.19 %
UOF18 (Central Emergency Response Fund "CERF")		Activity 01	Provided trauma care services, rehabilitation, and reproductive health services to girls, boys, women, and men	Kunduz and three	247516.87	218574	88.31 %
UOF68 (Central Emergency Response Fund "CERF")		Activity 01	Provided life-saving critical reproductive health interventions to (girls, boys, women, and men) at Torkham Border (Zero points) and IOM transit center	Kunar, Laghman, Nangarhar and Kabul	268661.32	231686	86.24 %
HFA64 (UNOCHA)		Activity 01	Increase use of emergency lifesaving RH services by women of CBA including pregnant women	Nangarhar, Helmand, Kandahar, Paktika, Kunduz, and Faryab	587535.72	359589	61.20 %

WFP01 (WFP)	Activity 01	Provide access to integrated Reproductive health and gender-based violence information women, men and girls among IDP, returnee and host communities receiving WFP food and nutrition assistance	Kabul and Nangarhar	461266	336739.37	73.00 %
AUA85 (DFAT)	Activity 01	An integrated approach to addressing the life-saving Reproductive Health needs of returnees displaced Afghans and host communities (particularly women and girls)	Kabul, Nangarhar, Kunar and Laghman	2699081.56	1764379.97	65.37 %
ITA38 (Italy)	Activity 01	Response to immediate Reproductive Health and GBV prevention and response needs of returnees, IDPs and host communities	Nimroz, Herat , Kunduz, Baghlan and Kandahar	663448	614541.87	92.63 %
FPA90	Activity 01	Recruit midwives for RH/GBV services conduct a rapid assessment on RH and GBV in emergencies, management support to midwives mobile health teams to provide RH services to childbearing age women in crisis-affected areas	Kabul	2,446,905.72	2,339,261.13	95.60 %

ADOLESCENTS AND YOUTH

Strategic plan outcome: (descriptions as per CPD):
SP Outcome 2: Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased the availability of comprehensive sexuality education and Reproductive health.
UNDAF Outcome 2: Basic Social Services: All Afghans, especially the most marginalized and vulnerable, have equitable access to and use of quality health, nutrition, education, WASH, prevention and protection services that are appropriate and effectively address their rights and needs.

Country Programme Output: Increased national capacity to conduct evidence- based advocacy for incorporating the rights and needs of adolescents and youth in national laws, policies and programmes, in particular healthy family life education and youth-friendly services

Annual work plan (code and name)

AUA85 (DFAT)		Activity 01	An integrated approach to addressing the life-saving Reproductive Health needs of returnees displaced Afghans and host communities (particularly women and girls)	Kabul, Nangarhar, Kunar and Laghman	608,958.41	373,546.05	61.34 %
EUB06 (EU)		Activity 01	Increasing the use of modern contreception prevelance rate (mCPR), Increased demand for family planning services, Improved male involvement in FP services and increased FP knowledge of adolecents and young people	Nangarhar, Laghman, Kunar, Samangan, and Badakhshan	618,643.60	575,183.03	92.97 %
FPA90		Activity 01	Establish 6 youth-friendly corners	Kabul, Kandahar, Mazar, Jalalabad	2,796,025.95	2,621,528.32	93.76 %
GENDER EQUALITY							
Strategic plan outcome: (descriptions as per CPD): **SP Outcome 3:** Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth. **UNDAF Outcome 3:** Social Equity and Investment in Human Capital: Social equity of women, youth, minorities and vulnerable populations is increased through the Government's improved and consistent application of principles of inclusion in implementing existing and creating new policies and legislation. **UNDAF Outcome 3:** Justice and Rule of Law: Trust in and access to fair, effective, and accountable rule of law services is increased in accordance with applicable international human rights standards and the Government's legal obligations							
Country Programme Output: Strengthened capacities of health sector, and law- enforcement bodies for the prevention, response and monitoring of gender-based violence and child marriage in targeted provinces							
Annual work plan (code and name)							
UKB12 (DFID)		Activity 01	Increasing Access to Gender-Based Violence (GBV) response services in six provinces of Afghanistan: Implementing the GBV Health Sector Response Model	in Laghman, Parwan, Kapisa, Daikundi, Farah and Jawzjan	2,714,918.00	2,476,526.47	91.22 %

KRA07 (Korea)		Activity 01	Coordinated multi-sectoral response to Gender-Based Violence through the integration of professional assistance and referral services into the health sector	Kabul, Baghlan, Nangarhar, Balkh and Bamyan	2,062,258.00	1,832,979.43	88.88 %
ITA38 (Italy)		Activity 01	Response to immediate Reproductive Health and GBV prevention and response needs of returnees, IDPs and host communities	Nimroz, Herat , Kunduz, Baghlan and Kandahar	522,746.13	392,165.47	75.02 %
AUA61 (DFAT)		Activity 01	Strengthening the capacity of Afghanistan's National Police Force and other legal actors towards combating violence against women and girls	Kabul, Parwan, Kapisa, Panjsher, Nangarhar, Bamyan, Daikundi, Kunar, Laghman, Khost, Paktia, Saripol, Kandahar, Balkh, Herat and Baghlan	2,133,690.56	2,078,606.58	97.42 %
AUA92 (DFAT)		Activity 01	Strengthening the capacity of Afghanistan's National Police Force and other legal actors towards combating violence against women and girls	Badakhshan, Baghlan, Balkh, Bamyan, Daikundi, Farah, Ghor, Herat, Kabul, Kandahar, Kapisa, Khost, Kunar, Laghman, Logar, Nangarhar, Nimruz, Paktia, Paktika, Panjsher, Parwan, Sari-pol, Samangan, Takhar, Wardak and Zabul	1,456,258.00	1,234,311.16	84.76 %

ITA32 (Italy)		Activity 01	Increase access to life-saving RH and GBV prevention and response services for 100,000 women, girls, boys and men from returnee, IDP and host communities in affected populations concentrated	Baghlan, Kunduz, Herat, and Nimruz	2,750,123.10	2,255,015.00	82.00 %
KRA23 (Korea)		Activity 01	Increasing Access to GBV Response Services in 11 provinces of Afghanistan: Implementing the GBV Health Sector Response Model	Nangarhar, Kabul, Balkh, Bamyan, Baghlan, Samangan, Ghor, Faryab, Khost, Paktya and Badghis	3,211,005.78	2,356,984.29	73.40 %
AUA85 (DFAT)		Activity 01	An integrated approach to addressing the life-saving Reproductive Health needs of returnees displaced Afghans and host communities (particularly women and girls)	Kabul, Nangarhar, Kunar and Laghman	1,763,538.16	1,118,669.00	63.43 %
UKB37 (DFID)		Activity 01	Increasing Access to GBV Response Services: Implementing the GBV Health Sector Response Model	Daikundi, Farah, Jawzjan, Laghman, Kapisa and Parwan, and expansion to six new provinces of Logar, Wardak, Ghazni, Takhar, Saripul and Urozgan	624,985.00	171,664.27	27.47 %
CAA38 (Canada)		Activity 01	Addressing violence against women and girls for internally displaced person	Nangarhar	103,996.00	94,434.82	90.81 %
ITA22 (Italy)		Activity 01	Creating safe and non-violent environments for women and girls	Herat	1,041,228.66	807,233.24	77.53 %

JPA32 (Japan)		Activity 01	Strengthening the capacity of Afghanistan's National Police Force and other legal actors towards combating violence against women and girls" in seven provinces of Afghanistan	Herat, Balkh, Badghis, Farah, Faryab, Jawzjan and Ghor	1,543,382.48	1,461,270.22	94.68 %
UKA96 (DFID)		Activity 01	Increase access and utilization of GBV response services in six provinces of Afghanistan	Daikundi, Farah, Jawzjan, Laghman, Panjsher and Parwan	1,342,620.00	1,219,161.79	90.80 %
UOF19 Central Emergency Response Fund "CERF")		Activity 01	Provision of life-saving multi-sectoral services for gender-based violence	Kunduz	290,322.00	279,548.17	96.29 %
FPA90		Activity 01	Technical assistance to the ministry of women affairs and ministry of interior affairs	Kunduz	2,647,002.91	2,399,381.96	90.65 %
POPULATION DYNAMICS							
Strategic plan outcome: (descriptions as per CPD): **SP Outcome 4:** Strengthened national policies and international development agendas through the integration of evidence-based analysis on population dynamics and their links to sustainable development, Reproductive health and reproductive rights, HIV and gender equality. **UNDAF Outcome 5:** Accountable Governance: Improved legitimate, transparent and inclusive governance at all levels that enables progressive realization of human right							
Country Programme Output: 1) Increased availability of national and local data, disaggregated by sex and age, to formulate, implement and monitor policies and programmes 2) Increased capacity of government counterparts, parliamentarians and academic institutions, in data utilization and advocacy for policy development, planning, and monitoring of programmes on youth, gender equality and reproductive health.							
Annual work plan (code and name)							
USA43 (USAID)		Activity 01	Conduct Socio-Demographic and Economic Survey	Herat, Nimroz, Baghlan and Badghis	6,214,346.41	5,831,325.00	93.84 %
UKA94 (DFID)		Activity 01	Conduct the SDES	Balkh, Kabul, Samangan and Takhar	14,456,185.08	11,703,266.93	80.96 %

UDA38 (UNDP)		Activity 01	Population estimation/count of Afghanistan	34 provinces of Afghanistan	111,111.11	111,055.99	99.95 %
JPA22 (Japan)		Activity 01	Socio-Demographic and Economic Survey	Ghor, Daikundi, Parwan, and Kapisa	2,339,007.83	2,037,539.37	87.11 %
UKA78 (DFID)		Activity 01	Socio-Demographic and Economic Survey	Kabul and Samangan	2,716,703.70	2,384,703.00	87.78 %
FPA90		Activity 01	Hire a consultant to provide technical assistance to Kabul university to review resources materials for a course on demography and population studies, provide technical assistant to MoPH for implementation of CRVs strategy	Kabul	3,035,732.16	2,740,422.52	90.27 %

Annex 5: Evaluation Matrix

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
Relevance **EQ1:** To what extent is UNFPA support in the fields of RH and rights, youth development, population and development, and gender equality (i) adapted to the needs of the population, particularly of the most vulnerable and marginalized, ii) adapted to priorities or shifts caused by crisis or major political change and (iii) in line with the priorities set by the national policy frameworks?			
Assumption 1.1: UNFPA Country Programme were adapted to the needs of the populations, particularly of the most vulnerable and marginalized	• Evidence of an exhaustive and accurate identification of the needs prior to the programming of RH, PD and Gender Equality by UNFPA and/Implementing partners • Evidence of systematic use of findings from needs assessments in programme planning and design and the selection of target groups for UNFPA-supported interventions in the four thematic areas of programming in line with identified needs (as detailed in the needs assessments) as well as priorities in the CPD and AWPs. • Extent to which the targeted populations, including vulnerable and marginalized groups, such as people with disabilities, were consulted in relation to programme design and activities throughout the programme	• Country Programme Document (CPD) and AWPs • National policy/ strategy documents • Needs assessment studies • UNDAF • Country Office staff • IPs, key actors	• Document review • Interviews with UNFPA CO staff • Focus groups discussions with beneficiaries • Interviews with IPs and key actors
Assumption 1.2: UNFPA Country Programme were adapted and adequately responded to priorities or shifts caused by crisis or major political change	• Evidence of repeated needs assessments conducted by UNFPA and/or implementing partners, identifying the varied needs of diverse groups and lessons learnt during programming in the four thematic areas of programming • Extent to which development and humanitarian interventions in the four thematic areas of programming were adapted to emerging needs, demands and priorities of the population, in particular the most vulnerable, disadvantaged, marginalized and excluded population groups (as detailed in the needs assessments). • Evidence of UNFPA conducting needs assessments and/or contributing to joint needs assessments in the four thematic areas of programming at the onset of humanitarian crises • The speed and timeliness of response (response capacity)	• CPD and AWPs • National policy/ strategy documents (PDP, PPMP) – • Rapid Needs assessment reports • UNDAF • Country Office staff	• Document review • Interviews with UNFPA CO staff • Focus groups discussions with beneficiaries • Interviews with IPs and key actors

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
	▪ Adequacy of the response (quality of the response) in meeting needs of beneficiaries, especially of the most vulnerable and marginalized groups.		
Assumption 1.3: UNFPA Country Programme were consistent with the national priorities in the national policy frameworks in the areas of RH, A&Y, GEWE and PD.	▪ The extent to which UNFPA-supported interventions have appropriately taken into account the priorities of the Government of Islamic Republic of Afghanistan (GoIRA) and key stakeholders. ▪ Choice of beneficiaries for UNFPA- supported interventions are consistent with identified needs as well as national priorities in the AWPs, including women, youth and other vulnerable groups ▪ Extent to which the objectives and strategies of the Country Programme and Annual Plan(s) have been discussed and agreed upon with a wide array of national stakeholders at national and provincial levels	▪ National policies and strategies ▪ Implementing partners (State actors, implementing NGOs) at the national and provincial levels ▪ Program beneficiaries (PLW; young people, girls and boys) ▪ AWPs ▪ UNFPA CO Staff ▪ Needs assessment studies ▪ Implementing Partners	▪ Document review ▪ Interviews with UNFPA Staff, IPs and Government ▪ Focus group discussions with beneficiaries
Relevance **EQ2:** To what extent is the Country Programme (2015-2019 and its extension to 2021) aligned with the UNFPA Strategic Plan 2018-2021 and One-UN Mutual Accountability Framework 2018-2021, and Sustainable Development Goals.			
Assumption 2.1: The Country Programme is aligned with the UNFPA Strategic Plan 2018-2021 and One-UN Mutual Accountability Framework 2018-2021, and Sustainable Development Goals.	▪ Evidence of CPD, CPAP(s) and AWPs reflecting One-UN Mutual Accountability Framework, and SDG goals and the core strategy of UNFPA ▪ Proportion of needs assessments and proposals that are aligned with the SDGs and the UNFPA Strategic Plan 2018-2021. ▪ Extent to which the interventions implemented on the ground are in line with the SDGs and the UNFPA Strategic Plan 2018-2021 ▪ The expected results, targets and implementation strategies outlined in the CPD, CPAP(s) and the AWPs are in line with the priorities, results and targets of the (UNDAF) 2018-2021	• UNFPA Strategic Plan 2018-2021 and annexes • CPD 4th UNFPA Afghanistan CP (2015-2019 and its extension to 2021) • UNDAF 2015-2019 and annexes • One-UN Mutual Accountability Framework 2018-2021 • UNDAF 2015-2019 MTR • CO staff, • Staff of respective UN partners • Government officials at National and provincial levels • Needs assessments • Proposals • CPAP and AWPs	• Document review • Interviews with UNFPA Country Office staff • Interviews with staff of United Nations agencies • Interview with government officials • Interviews with implementing partners • Interviews with other development actors (i.e., NGOs/groups working in the areas in which UNFPA works, but that do not partner with UNFPA)

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
Effectiveness **EQ3**: To what extent have the 4th CP outputs been achieved, and to what extent have these outputs contributed to the achievement of the 4th CP outcomes?			
Assumption 3.1: The 4th CP planned outputs have been achieved, and contributed to the achievement of the outcomes across all the thematic areas	• Extent to which M&E of programmes and projects indicate the achievements of outputs in the M&E Framework against indicators • The extent to which outputs in the CP and Results and Resources Framework are likely to have contributed to outcome results across the CP theory of change • Extent to which M&E of programme achievements indicate timely meeting of outputs.	• The Global Programming System (GPS), AWP and annual reports (SIS) • Annual Review and Planning reports • Review reports and other related documents • IPs (government, NGOs, and other institutions) • UNFPA CO staff • CP Results Framework • CP Theory of Change • IP Progress reports • Beneficiary groups / communities • Quarterly and annual implementation progress reports • Relevant evaluation reports • UNCT reports • Relevant programme, project and institutional reports	• Document analysis • Interviews with CO staff • Interviews with line ministries and other IPs • FGDs with beneficiaries • Field visit to programme sites, and beneficiaries at the locations
Assumption 3.2: UNFPA adequately contributed to the Humanitarian preparedness and response in Afghanistan, addressing the RH and rights, and Gender issues for the pregnant and lactating women, young people, and women of reproductive age in general.	• Extent to which the design, implementation and monitoring of UNFPA CP supported humanitarian assistance to the vulnerable populations in the target areas or other parts of the country during humanitarian crisis. • Evidence of allocation of resources in the CPD design, implementation and monitoring in addressing humanitarian response • Evidence of UNFPA CP achievements on humanitarian preparedness and response reflected in the CP reports • Existence of prepositioning of materials or support mechanisms for emergency response in the areas of RH and GBV by the UNFPA CP • Information and monitoring system for RH, GBV, adolescent and youth service provision for most vulnerable segments during emergencies in place	• Humanitarian Response Plans • Humanitarian programming documents • Annual Review and Planning reports • CP Results Framework • UNFPA CO staff • HCT members • Implementing partners	• Document review • Interviews with UNFPA Country Office staff • Interviews with other United Nations agencies • Interview with government officials • Interviews with implementing partners • Interviews with other development actors (i.e., NGOs/groups working in the areas in which UNFPA works, but that do not partner with UNFPA)

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
Effectiveness **EQ4**: To what extent did the country programme integrate a gender-responsive and human rights-based approach to programme planning, implementation, and monitoring?			
Assumption 4.1: Gender-responsive and human rights-based approaches to programme planning, implementation, and monitoring is evident in the CP	• Extent to which a gender-responsive and human rights-based approach was integrated in situation assessment and analysis, planning and design, implementation and monitoring and evaluation of UNFPA-supported interventions in the four thematic areas of programming • Evidence of increased incorporation of a gender-responsive and human rights-based approach in Government policies, strategies and plans at national and provincial levels during the period of the Country Programme • Evidence of inclusive and participatory mechanisms to systematically seek input from target populations in the design, implementation and monitoring of UNFPA-supported interventions in the four thematic areas of programming • Presence of accountability mechanisms for populations affected by humanitarian crisis, such as complaints mechanisms to report sexual exploitation and abuse by UNFPA staff and/or implementing partners	• AWPs and SISs/APRs • CO staff • Government and key stakeholders • CP documents • Government and key partners • Key government policies, strategies and plans at national and county levels • IP progress reports • Beneficiaries	• Document review • KI interviews with UNFPA staff, Government and IPs • FGDs with beneficiaries
Sustainability **EQ5**: To what extent has UNFPA been able to support its partners and the beneficiaries (women, adolescents and youth) in developing capacities and establishing mechanisms to ensure ownership and the durability of effects as well as established and maintained different types of partnerships across programme components during CP implementation and exit strategy UNFPA applied to ensure smooth transfer of its support to the national counterparts?			
Assumption 5.1: National ownership regarding the UNFPA programme areas and integrated planning and programming have been strengthened	• Evidence of increased programme integration in GoIRA sector policy frameworks in the programme country and national development plans • Extent to which UNFPA has taken any mitigating steps to strengthen areas with gaps hindering sustainability	• AWPs, • SIS and Annual Planning Reports • GoIRA policies and development plans	• Document review • Interviews with GoIRA and IPs • Interviews with UNFPA staff

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
	• Evidence of GoIRA contribution to the UNFPA programme areas • Evidence of increased resource allocation by the government on the UNFPA-supported programme areas • Government and Stakeholders effectively utilize data generated through the CP support • Evidence of the development of exit strategies in the four thematic areas of programming to hand over UNFPA-supported interventions to Government and/or implementing partners at national and sub-national levels • Extent to which programmes in the four thematic areas of programming were developed and implemented in a participatory multi-stakeholder process to promote ownership	• UNFPA CO staff	• Focused group discussions with the beneficiaries
Assumption 5.2: UNFPA partners have the technical capacity and the resources to contribute effectively to UNFPA supported interventions in all programme areas, in their policies, programmes and budgets	• Evidence of increased technical capacity in UNFPA programme areas • Evidence of ongoing benefits after the interventions have ended • Evidence of GoIRA and implementing partners at national and sub-national levels allocating adequate budget for continued implementation of interventions and safeguarding the gains that have been made in the four thematic areas of programming. • Evidence of policies, plans and programmes necessary to support continuity of the CP results • Evidence for enhanced capacity of the Government and implementing partners at national and sub-national levels to implement interventions in the four thematic areas of programming without the technical support of UNFPA	• AWPs, Annual Planning Reports • Programme and project evaluations • UNFPA CO staff • Key partners • Beneficiaries	• Document review • Interviews with UNFPA CO staff and key partners • FGDs with beneficiaries
Assumption 5.3: UNFPA programme beneficiaries have increased knowledge and capacity regarding RHR, Adolescent and youth and GBV and greater access to and uptake of quality services	• Evidence in planning documents and reports of knowledge and capacity building efforts in beneficiaries • Evidence of expanded and integrated high quality services for RHR, adolescent and youth, and GBV at all levels established and sustainable	• AWPs • Annual planning reports • GoIRA and key partners • Beneficiaries • IPs	• Document review • Interviews with UNFPA CO staff and key partners • FGDs with beneficiaries

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
Efficiency **EQ6:** To what extent has the CO made good use of its human, financial, technical, and administrative resources, and has used an appropriate combination of tools and approaches to pursue the achievement of 4th CP outcomes promptly?			
• **Assumption 6.1:** Implementing partners received UNFPA financial and technical support as planned and in a timely manner, and UNFPA was able to mobilize appropriate resources in a timely manner to support the implementation of the Country Programme.	• Evidence that implementing partners received the planned resources to the foreseen level in AWPs • Evidence that implementing partners received resources in a timely manner • Evidence of coordination and complementarity among the programme components of UNFPA	• AWPs and APRs/SIS and IP, government reports • UNFPA CO financial reports • UNFPA CO staff • Government officials • Implementing partners • Resource mobilization strategy	• Document review • Interviews with UNFPA CO staff and key partners • GoIRA and IP staff interviews
• **Assumption 6.2:** The UNFPA main and sub-offices were appropriately staffed (the right number of people with the right competencies and skills in the right positions)	• Evidence that UNFPA personnel (all types of contracts) have adequate expertise and experience to deliver development and humanitarian assistance • Evidence that UNFPA CO staffing structure is appropriate for timely and effective implementation, including in humanitarian settings • Extent to which existing human resource management policies, rules and procedures enable the timely and effective implementation, including in humanitarian settings	• UNFPA CO Staff interviews • HR structure	• Documentary review • Key Informant and group interviews
Assumption 6.3: Programme strategic approaches, administrative, procurement and financial procedures as well as the mix of implementation modalities led to efficient achievement of programme outputs	• The planned inputs and resources were received as set out in the AWPs and agreements with partners. • The resources were received in a timely manner according to project time lines and plans • Budgeted funds were disbursed in a timely manner • Quality technical assistance to build capacity was available to the level planned • Evidence that technical assistance increased capacity among recipient stakeholders • Inefficiencies were corrected as soon as possible	• AWPs and APRs/SIS and IP, government reports • UNFPA CO financial reports • UNFPA CO, government and IP staff	• Document review • Interviews with CO, GOIRA and IPs staff
Assumption 6.4: CP has robust M&E systems are in place and efficiently utilised	• Evidence of M&E system and documentation • Evidence of utilization of M&E information in informing the programme strategies	• CP Resource and Results Framework • Programme Reports (SIS and Annual Planning reports • UNFPA CO Staff	• Document review • Interviews with CO, GOIRA and IPs staff

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
Coordination **EQ7:** To what extent has the UNFPA CO contributed to the functioning and consolidation of UN Country Team (UNCT) coordination mechanisms?			
Assumption 7.1: The UNFPA CP has actively contributed to the UNCT working groups and joint initiatives	• Evidence of active participation in UN inter agency working groups • Evidence of the leading role played by UNFPA in UN inter-agency working groups or joint initiatives • Evidence of exchanges of information between UN agencies • Evidence of joint programming initiatives; plans for joint programming • Evidence of UNFPA actively contributing and taking initiative in UNCT meetings • Evidence of UNFPA playing a leading role in thematic working groups of the UNCT relevant to the UNFPA mandate	• Programming documents regarding UNCT joint initiatives • Monitoring and evaluation reports of joint program and projects • UNCT members, CO staff • SIS and other programme reports • UNDAF Reports • Respective UN agency staff	• Documentary review • Interviews with UNFPA CO staff • Interview with the UNRC • Interviews with UNCT other UN agency members
Added Value **EQ8:** What is the main UNFPA added value in the country context as perceived by national stakeholders?			
Assumption 8.1: UNFPA CO has demonstrated specific technical contribution to the country's development agenda	• Extent of contribution to added value by UNFPA comparative strengths in the country – particularly in comparison to other United Nations organizations. • UNFPA's comparative strengths in their regular programming as perceived by international and national counterparts (GoIRA, CSO and other institutions) • Status of national capacities to contribute to the issues/areas that UNFPA is contributing to	• UNDAF reports • CPD reports • Key development partners • Government Staff • Key NGOs • Donors • UN agency Staff	• Document review • Interviews with CO, GOIRA and IPs staff
Assumption 8.2: UNFPA CO strategic leadership in the CP-related components contributed to stronger capacities of government and other development partners to deliver quality RH services and GBV response, among other components areas especially to the most vulnerable segments	• Training brand, as distinguished from training provided by other development partners • Evidence of knowledge products • Evidences of UNFPA taking leadership in spearheading particular agenda on RH, GBV, PD and Adolescent and Youth	• Key development partners • Government Staff • Key NGOs • Donors • UN agency Staff • UNDAF reports • CPD reports	• Document review • Interviews with CO, IPs, Donors, and GoIRA, staff
Assumption 8.3: UNFPA CO has entered into strategic partnerships at the local level that produced results and are worth	• Other development partners adopting UNFPA strategies and good practices	• Key development partners • Government Staff • Key NGOs, Donors • UN agency Staff	• Document review • Interviews with CO, IPs, Donors, and GoIRA, staff

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
replicating and institutionalizing		▪ UNDAF and CPD reports	
Coverage **EQ 9:** To what extent has the UNFPA humanitarian response reached those most in need and vulnerable in crisis situations both geographically and demographically?			
Assumption 9.1: The UNFPA humanitarian support systematically reaches all geographic areas in which women, adolescents and youth are in need, as well as the geographic areas that are most at risk and vulnerable to humanitarian crises.	• Evidence of needs assessment conducted by UNFPA and/or implementing partners, identifying the varied needs of vulnerable populations in various geographical areas in the country prior to the programming of the RH, A&Y, P&D and gender components of the CPD • Evidence of systematic use of findings from needs assessments in programme planning and design and the selection of target groups for UNFPA-supported interventions in the four thematic areas of programming in line with identified needs (as detailed in the needs assessments) as well as priorities in the CPD and AWPs. • Extent to which the planned interventions in the four thematic areas of programming, as described in the AWPs, were targeted at the most at risk groups in a prioritized manner. • Extent to which the actual interventions implemented on the ground met the needs of the most at risk groups. • Extent to which the most at risk groups were consulted in relation to programme design and activities throughout the programme	• UNFPA CO M&E Framework • Strategic Information System (SIS) annual reports. • Needs assessment studies (incl. Humanitarian Needs Overviews) • Evaluations – Evaluation of the 3rd Country Programme and other UN agencies in the same thematic areas of focus. • Key Informants from Government, CSOs and UNFPA CO • Direct and indirect beneficiaries.	• Document review • KI interviews • Focus groups with beneficiaries and communities in targeted sites • Focus groups with direct and indirect beneficiaries and communities in targeted sites •
Assumption 9.2: The UNFPA humanitarian support systematically reaches demographic populations of vulnerability and marginalization (i.e. women, girls, and youth with disabilities; displaced women, adolescents and youth within and outside camps; the elderly; female-headed households; women and adolescents and youth from minority clans, etc.).	• Evidence of UNFPA responding to protection needs of the affected population in the country • Evidence of UNFPA response targets vulnerable and marginalized in Afghanistan • Evidence of UNFPA programme supporting creation of humanitarian space to reach the vulnerable populations in Afghanistan • Extent to which the planned UNFPA interventions in the four thematic areas of programming, as described in the AWPs, were targeted at the most vulnerable, disadvantaged, marginalized and excluded population groups in a prioritized manner.	• UNFPA CO M&E Framework • Strategic Information System (SIS) annual reports. • Needs assessment studies (incl. Humanitarian Needs Overviews) • Evaluations – Evaluation of the 3rd Country Programme and other UN agencies in the same thematic areas of focus. • Key Informants from Government, CSOs and UNFPA CO	• Document review • Interviews with IPs, CO, GoIRA and UN staff • Focus groups with beneficiaries and communities in targeted sites • Focus groups with direct and indirect beneficiaries and communities in targeted sites

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
	• Extent to which the actual interventions implemented on the ground met the needs of the most vulnerable, disadvantaged, marginalized and excluded population groups. ▪ Extent to which the vulnerable and marginalized were consulted in relation to programme design and activities throughout the programme	▪ Direct and indirect beneficiaries.	
Connectedness **EQ10:** To what extent does UNFPA humanitarian action and plan for longer-term development goals articulated in the results and resources framework of the 2018-2020 Country Programme and contribute to resilience building?			
Assumption 10.1: UNFPA response to humanitarian crises supports and plans for longer-term development goals articulated in the results and resources framework of the 2015-2021 Country Programme and contributes to building resilience by enhancing capacities at individual, community and systems level and bridging the development-humanitarian-peace nexus.	• Evidence of the existence of an exit strategy with timelines, allocation of responsibility • Evidence of details of a handover process from UNFPA to the government departments and/or development agencies • Evidence of allocation or plan for resource allocation post-response • Evidence that affected communities are mapped and targeted with interventions • Evidence of the existence of a transition strategy from humanitarian action to development, which specifies timelines, allocation of budget and roles and responsibilities • Extent to which the capacity of individuals, in particular women, adolescents and youth, has been increased to reduce vulnerability to and adapt to humanitarian crises, as well as transform livelihoods to successfully cope with humanitarian crisis • Extent to which the capacity of communities to prepare for, mitigate the impact of, and recover from humanitarian crisis has been enhanced • Extent to which the preparedness of the health and social protection systems at federal and state levels and the capacity to deliver services in the mandate areas of UNFPA has been increased • Extent to which UNFPA humanitarian assistance was linked specifically to peacebuilding initiatives	• Results and resources Framework • UNFPA Staff • Government staff • NGO/IP Staff • Programme reports	• Document review • Interviews with staff • Group Interviews

Annex 6: Data Collection Tools

Key Informant Interview Guide for UNFPA Staff and UN Agencies

Introduction:

a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the next CP cycle.
b. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.
c. Write names of all participants and their roles in the organization
d. **Probe: Focus on vulnerability, gender, disability and human rights as appropriate**

1. Rationale for the 4th CP and Interventions undertaken

- How did you decide to undertake this work, what were the indications that it would be effective and would reach the target population**, specific target groups, including women and girls/people with disabilities**?
- Who was consulted regarding the design? To what extent were they consulted?
- What other actors have been involved, how does this activity contribute to that of others?

2. Relevance

- How is the [RHR, A&Y, GEWE or PD] component of the 4th Country Programme (CP) aligned to the a) national needs and priorities in Afghanistan such as articulated in the national and sectoral policies b) Partners and beneficiaries needs? c) UNFPA Strategic Priorities and strategic plan? d) International frameworks, policies and strategies on [RHR, A&Y, GEWE or PD] and human rights? **(probe for the needs first)**
- What aspects of the national and sectoral policies do you consider are covered in the 4th CP?
- Were the objectives and strategies of the Country Programme M&E Framework discussed and agreed with national partners? [Probe]
- How did you identify the needs prior to the programming of the [RHR, A&Y, GEWE or PD] components?
- Who was consulted regarding the design? What other actors have been involved, how does this activity contribute to that of others?
- In your view, does UNFPA have the right strategic partnerships? Mutual benefit, critical to achieving shared vision
- Were there any [RHR, A&Y, GEWE or PD] needs or priorities of the implementing partners that the country program did not address adequately or at all? If Yes, what were these needs and Priorities of the most vulnerable and marginalized groups, including people with disabilities.

3. Effectiveness

- What are the indications that the approach is working or making progress toward goals established for the CP (e.g. anecdotes which provide illustrations of positive, negative or unintended effects, or quantitative and qualitative evidence)?
- Overall, what are the achievements of the 4th CP in respect of the [RHR, A&Y, GEWE or PD] component area (include humanitarian programme)**? Probe** for evidence
- How have the outputs been utilized?
- What are the barriers/challenges to increasing demand and access to services, and how are they being addressed?
- What factors have facilitated effective implementation of the 4th CP? Which ones hindered?
- What do you consider to be the best practices from the 4th CP?
- Were there unintended effects/ results (**can be positive or negative)**
- To what extent did internal communication strategies on various CP components facilitate improved outcomes of the other components in terms of funding, personnel, administrative arrangements, time and other inputs contributed to, or hindered achievement of results.

- Were there any changes in national needs and global priorities during the implementation period? How did UNFPA CO respond to these changes?
- To what extent has UNFPA responded to [RHR, A&Y, GEWE or PD] emerging issues in the IDP Settlements or calamities? What were the factors that facilitated UNFPA response to such emerging issues? What were the factors that hindered the UNFPA response to such RHR emerging issues?

Note: Remember to ask for documents if not already shared

4. Efficiency

- How many staff are in your unit? Qualified with appropriate skills?
- Do you think your staff strength and capacity are enough for the 4th CP implementation and achievement of results?
- How timely did you receive resources for implementing this programme?
- How timely were resources for interventions disbursed to implementing partner? Were the resources sufficient for implementing partners to complete activities?
- Describe UNFPA CO administrative and financial procedures in the 4th CP?
- Do you think UNFPA CO administration and financial procedures are appropriate for the 4th CP implementation? **[Probe]**
- Were there any delays? If yes, why? And how did you solve the problem?
- Are there occasions when the budget was not enough or you overspent?
- How appropriate was the programme approach, partner and stakeholder engagement for CP implementation and achievement of results?
- Have the programme finances been audited?
- To what extent were the activities managed in a manner to ensure delivery of high quality outputs and best value for money?
- Any additional funding from the GoIRA and other partners?
- How robust and adequate is the M&E System in place to enable measurement of the CP performance during implementation? How are M&E results used to support the CP management?

5. Sustainability

- What mechanisms is UNFPA putting in place to ensure that the results of the CP are sustained beyond the programme cycle?
- How is partner capacity building integrated into UNFPA mode of engagement with partners?
- How have national partners utilized capacity developed through UNFPA support?
- How are national partners involved in UNFPA programming?
- To what extent are the benefits likely to go beyond the programme completion?
- Are the strategies, plans, protocols and practices developed within the programme anchored on IPs institutional arrangements
- Do you believe that there is political will and national ownership behind the CP interventions, and is this changing? Have programmes been integrated in institutional government plans?
- How has UNFPA addressed changes in knowledge and perceptions of the target beneficiaries based on various aspects of the programme?

6. UNCT Coordination

- Is there any Inter-Agency Technical Working Group on this 4th CP, involving other UN Country Team?
- What role has UNFPA played in the UNCT joint programs? Any specific contributions? Any lessons learned?
- What are the UNCT coordination structures and mechanisms in place?
- How active, relevant and effective is UNFPA in the UNCT?
- What is the role of UNFPA CO in the United Nations Country Team coordination structures and mechanisms in Afghanistan? What partnerships exist? Any specific contributions to the achievement of results?

- What are the special strengths of UNFPA when compared to other UN agencies and development partners?
- How do implementing and national partners perceive UNFPA?
- Is UNFPA collaborating with other UN Agencies in implementation of interventions? Which UN Agencies and in which interventions? What are the roles of UNFPA and other UN Agencies? How has this contributed to achievement of UNFPA results?
- How and to what extent are UNFPA priorities and mandate reflected in the UNDAF

7. Added Value

- What unique strategies/interventions in RH, A&Y, P&D or Gender of UNFPA add value to the work of other development partners, especially the UN system? Please give examples
- What strategic partnerships at the National level and /or local level has UNFPA supported that produced results and are worth replicating and institutionalizing?
- What specific technical contribution has UNFPA made to the country's development agenda

8. Coverage

- How does UNFPA CP respond to humanitarian needs in Afghanistan? In which locations? Who were the target groups?
- How does UNFPA programme identify those at risk or vulnerable?
- To what extent does UNFPA programme target the vulnerable and those in displacement in Afghanistan?
- To what extent has UNFPA responded to RH on the humanitarian and emerging needs in the IDP Settlements or calamities?
- What were the factors that facilitated UNFPA response to such adolescent and youth humanitarian and emerging issues?
- What were the factors that hindered the UNFPA response to such humanitarian and emerging issues?
- To what extent does the UNFPA CP interventions address the needs of populations at risk and vulnerable?
- Budget allocation for humanitarian programme interventions

9. Connectedness

- To what extent has UNFPA built the capacities of local partners during the current CP? What are the indications that the capacity building efforts are working?
- How has UNFPA built partnerships with local organizations or institutions in the areas of RHR in Afghanistan?
- How adequate have the resources allocated to addressing emergency response been to ensure recovery and resilience
- How has UNFPA ensured that long-term plans are put in place to address the existing RHR
- Have the facilities supported by UNFPA to respond to emergency been handed over to the local government or local communities?

Key Informant / Group Interviews: GoIRA/ IPs (adapted for **RHR, A&Y, GEWE and PD)**

Introduction:

a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current programme cycle with the view of proposing recommendations for the next CP cycle.

b. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.
c. Write the names of all the Participants and their roles in the organization
d. **Probe: Focus on vulnerability, gender, disability and human rights as appropriate**

1. Rationale of the Partnership and activities engaged in

- How did you decide to undertake this work, what were the indications that it would be effective and would reach the target populations (RHR, A&Y, GEWE and PD needs)?
- Have you conducted a problem analysis, needs assessment? Who was consulted regarding the design?
- What other actors have been involved, how does this activity contribute to that of others?

2. Relevance

- To what extent is the [RHR, A&Y, GEWE or PD] component of the 4th Country Programme (CP) aligned to the a) national needs and priorities in Afghanistan such as those articulated in the national and sectoral policies; b) International frameworks, policies and strategies on gender equality and human rights
- What aspects of the national and sectoral policies do you consider are covered in the 4th CP?
- How were needs of vulnerable groups (i.e. youth, girls, women, young mothers, marginalized, including people with disabilities) addressed during the programming or planning process for your UNFPA project activities?
- What criteria did you use in the selection of target groups in the field of [RHR, A&Y, GEWE or PD]? [**Probe** if the identified needs of these target groups included in the criteria]?
- Were there any [RHR, A&Y, GEWE or PD] needs or priorities of the implementing partners that the CP did not address adequately or at all? If Yes, what were these needs and Priorities
- How does the CP intervention interface/merge with your institutional programmatic objectives and strategies?
- How were needs of your institution identified prior to the programming of the [RHR, A&Y, GEWE or PD]?
- Do you see the work of UNFPA and its implementing partners as supporting the right interventions to address RH/GEWE/GBV/PD needs, harmful practices and discrimination against women and girls?

3. Effectiveness

- Looking at the implementation so far, to what extent have the planned 4th CP outputs/targets been achieved? Were the intended beneficiaries reached? **Probe** for humanitarian programme
- What are the indications that the approach is working or making progress toward goals established to be achieved in 2021?
- How did UNFPA provide support for challenges in the implementation of interventions to address outputs and outcomes.
- To what extent did the support address the needs of the target groups i.e. women of reproductive age, survivors of GBV, adolescents and youth, boys and men?
- What factors have facilitated effective implementation of the 4th CP? What factors hindered/affected successful implementation of the programme?
- What else should be done to make the programmes more effective?
- Has there been evidence of expected or unexpected results from work on RHR/GEWE/GBV/A&Y/PD that has been supported by UNFPA?
- How timely was the disbursement of UNFPA funds to the IPs? Probe for any challenges
- How many times did you experience a humanitarian crisis or a political change during the 4th CP? How did UNFPA support in each of the instances? Probe for the services or support provided
- To what extent has UNFPA responded to RHR emerging issues in the IDP Settlements or calamities? What were the factors that facilitated UNFPA response to such RHR emerging issues? What were the factors that hindered the UNFPA response to such RHR emerging issues?

- How did UNFPA ensure programme integration of gender and a human-rights ap,proach, including people with disabilities
- To what extent did UNFPA support use of disaggregated demographic and socio-economic data for evidence-based planning and development.

4. Sustainability

- What measures are in place for programme continuity in the absence of continued UNFPA support? [**Probe** e.g. re output/outcome areas integrated in institutional/government policies and plans/budget allocations]. In which areas do you need support to continue on your own?
- To what extent have your capacities been strengthened in the areas of support by UNFPA?
- How have you utilized capacity developed through UNFPA support?
- How is capacity building integrated into UNFPA mode of engagement with its partners?
- Do you have other sources of technical and financial support? **[Probe]**
- What is the likelihood of sustained benefits (e.g. through capacity building, improved M&E and other systems, population data availability, etc. with or without continued UNFPA support)? **[Probe]**
- How have UNFPA ensured effective partnership in the country to facilitate strong sectoral networks in the country? **Probe** how they have participated
- Is your organization/agency a member of any national or local coordination mechanism (including bi-lateral dialogues) where UNFPA shares technical expertise either as a member or as a leader? [**Probe**: What are these coordination mechanisms?

5. Efficiency

- How appropriately and adequately are the available resources (funding and resources) used to carry out activities for the achievement of the outputs?
- How timely did you receive resources for implementing this programme? Were there delays? If yes, why and how did you solve the problem?
- To what extent were the activities managed in a manner to ensure delivery of high quality outputs and best value for money?
- Any additional funding from the GoIRA or other partners for the programmes funded by UNFPA?
- Do you think UNFPA CO administration and financial procedures are appropriate for 4th CP implementation?
- How about the programme approach, partner and stakeholder engagement, was it appropriate for implementation and achievement of results?
- How did UNFPA support capacity development for implementers of interventions?
- What implementation challenges were encountered?
- Were agreed outputs delivered?
- Was the programme approach, partner and stakeholder engagement appropriate for results delivery?
- Which partnerships were more strategic in bringing about results and value-for money?
- Were institutions adequately equipped to deliver on results-based management/ M& E for the CP?

6. Coordination

- How is the UNFPA programme coordinated? What role does UNFPA play and what role do you play in coordination?
- Is there any Inter-Agency Technical Working Group on this 4th CP, involving other UN Country Team?
- Can you say how well the activities are coordinated, overlapping and how is this handled?
- Is UNFPA playing an active coordination or leadership role around RH, A&Y, GEWE and PD in the country?
- What are the special strengths of UNFPA when compared to other UN agencies and development partners?
- How do implementing and national partners perceive UNFPA?
- What partnerships exist? Any specific contributions to the achievement of results? Any challenges?

7. Added Value

- What unique strategies/interventions in RH, A&Y, P&D or Gender of UNFPA add value to the work of other development partners, especially the UN system? Please give examples
- What strategic partnerships at the National level and /or local level has UNFPA supported that produced results and are worth replicating and institutionalizing?
- What specific technical contribution has UNFPA made to the country's development agenda

8. Coverage

- How does UNFPA CP respond to humanitarian needs in Afghanistan? In which locations? Who were the target groups?
- How does UNFPA programme identify those at risk or vulnerable?
- To what extent does UNFPA programme target the vulnerable and those in displacement in Afghanistan?
- To what extent has UNFPA responded to RH on the humanitarian and emerging needs in the IDP Settlements or calamities?
- What were the factors that facilitated UNFPA response to such adolescent and youth humanitarian and emerging issues?
- What were the factors that hindered the UNFPA response to such humanitarian and emerging issues?
- To what extent does the UNFPA CP interventions address the needs of populations at risk and vulnerable?
- Budget allocation for humanitarian programme interventions

9. Connectedness

- To what extent has UNFPA built the capacities of local partners during the current CP? What are the indications that the capacity building efforts are working?
- How has UNFPA built partnerships with local organizations or institutions in the areas of RHR in Afghanistan?
- How adequate have the resources allocated to addressing emergency response been to ensure recovery and resilience
- How has UNFPA ensured that long-term plans are put in place to address the existing RHR
- Have the facilities supported by UNFPA to respond to emergency been handed over to the local government or local communities?

Key Informant Interview/ Focus group discussion Guide for CP Beneficiaries

Introduction:

a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the next CP cycle.
b. Seek consent and assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.
c. Capture every participant's name
d. **Probe: Focus on vulnerability, gender, disability and human rights as appropriate**

I would like to know the type of support you received from (**UNFPA implementing partner**)

1. Relevance

- What are the national needs and priorities in Afghanistan/in your community in terms of the development agenda with regards to CP component (RH, A&Y, GEWE and PD)?

- How important is the work supported by (UNFPA implementing partner) to these needs and priorities at the local, provincial and national levels?
- Does the (UNFPA implementing partner)'s work address the needs in (RH, A&Y, GEWE and PD)?
- How has (UNFPA implementing partner) consulted you in the identification of your local needs in (RH, A&Y, GEWE and PD)?
- How has (UNFPA implementing partner) integrated support for the marginalized, gender and other human rights?

2. Effectiveness
- To what extent has (UNFPA Implementing Partner) support reached the intended beneficiaries? **Probe** for vulnerable groups in the locality
- Are different beneficiaries appreciating the benefits of the UNFPA interventions? For example,
- What are the specific indicators of success in your programme?
- How are gender relations and human rights being influenced by the activities undertaken by the programme? Are there ways to sustain the positive changes?
- What are the barriers marginalized populations, vulnerable women, girls and PWD may face in accessing services and information?
- Are there any security factors that could affect the participation of the marginalized and vulnerable populations in certain aspects of the programme or to benefit from the programme interventions? To what extent are they prioritized by the service providers (e.g. duty bearers) – probe for gaps.
- What do you think has worked best? What has not worked well
- What factors contributed to the effectiveness or otherwise?
- What else should be done to make the programmes more effective?

3. Sustainability
- What are the benefits of the programme interventions to you?
- To what extent are the benefits likely to go beyond the programme completion?
- What measures are in place at the end of the programme cycle for the various programmes to continue?
- Have programmes been integrated in institutional/government plans?
- How does the UNFPA CO/ (Implementing partner) ensure ownership and durability of its programmes?

Interview Guide for UNFPA Donors and Strategic Partners

Introduction:

a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the next CP cycle.
b. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.
c. Capture every participant's name

Probe: Focus on vulnerability, gender, disability and human rights as appropriate

1. Rationale for the Strategic Relationship
- What is the strategic involvement of [Donor/ partner] in Afghanistan?
- What specific needs is your institution addressing in the country?
- Which specific areas did your institution support the Afghanistan 4th CP (Donor)?

2. Relevance

- How is UNFPA CP contributing to addressing the same strategy that your institution is involved in the country
- How relevant is UNFPA programming in addressing the country needs in the areas of (RH, A&Y, GEWE and PD)? [Probe for specific approaches]
- What is UNFPA's comparative advantage in the country?

3. **Effectiveness**
- To what extent would you say UNFPA is addressing the national needs and priorities in Afghanistan?
- What has been realized in the country because of UNFPA's CP since 2015 to present? [Results achieved compared to plans – Probe for capacities developed]
- What has worked well and what has not worked well?
- Are there gaps in UNFPA's approaches? How would they be improved?
- Efficiency and Sustainability
- M&E systems in place, ensuring
- Timely reporting
- Use of data to inform decision-making
- Capacities in place
- Effectiveness of partnership approaches

4. Coordination
- How active, relevant and effective is UNFPA in the coordination mechanisms in the country?
- How does UNFPA contribute to the coordination within the country? Probe for specific responsibilities
- Where there are areas of potential overlap with other UN mandates, how is this resolved? e.g. re gender, disability, human-rights based programming, response in humanitarian situations as well as main focal areas of RH, A&Y, PD
- What are UNFPA CO strengths, weaknesses/ limitations, and opportunities to improve in its programming in the country?

Annex 7: Stakeholder Map

Donors	Implementing Agencies	Other Partners	Beneficiaries
REPRODUCTIVE HEALTH			
Strategic plan outcome: (descriptions as per CPD): ***SP Outcome 1****: Increased availability and use of integrated 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.* ***SP Outcome 2****: Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programs, particularly increased the availability of comprehensive sexuality education and Reproductive health.*			

UNDAF Outcome 2: Basic Social Services: *All Afghans, especially the most marginalized and vulnerable, have equitable access to and use of quality health, nutrition, education, WASH, prevention and protection services that are appropriate and effectively address their rights and needs.*

Country program output: (descriptions as per CPD):

Output 1: Increased national institutional capacity to deliver a coordinated supply of modern contraceptives and improved quality of family planning services in selected provinces

Atlas project (code and name)

USA40 (USAID)	UNFPA	ACTD, MoPH	Ministry of Public Health of the Government of the Islamic Republic of Afghanistan to refine its family planning services to implement more targeted interventions. The secondary beneficiaries of this activity are development partners and stakeholders working in the area of family planning, maternal and new-born health, and population and development in Afghanistan
EUB06 (EU)	UNFPA	Afghan Family Guidance Association (AFGA), Agency for Assistance and Development of Afghanistan (AADA), MoPH	Increasing demand for FP; engaging men and boys in FP services, and equipping young Afghans with the necessary skills and knowledge to empower them to make informed, safe choices regarding FP in Badakhshan, Samangan, Kunar, Nangarhar, and Laghman provinces
FPA90-2018	UNFPA	AFGA, MoPH	Malalai obstetric fistula ward and ministry of public health and MoPH

Strategic plan outcome: (descriptions as per CPD):

SP Outcome 1*: Increased availability and use of integrated 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.*

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

UNDAF Outcome 2: Basic Social Services: *All Afghans, especially the most marginalized and vulnerable, have equitable access to and use of quality health, nutrition, education, WASH, prevention and protection services that are appropriate and effectively address their rights and needs.*

Country programme output: (descriptions as per CPD)

Output 2: Increased national institutional capacity to deliver comprehensive maternal health services to underserved populations

Atlas project (code and name)

AFG01 (IDB)	UNFPA	HEWAD, MoPH	Women of reproductive age with Obstetric Fistula
CAA36 (Canada)	UNFPA	MOVE, MoPH	Essential Reproductive, Maternal, Neonatal, and Child Health(RMNCH) services in Daikundi province
ITA15 (Italy)	UNFPA	Afghanistan's Centre for Training Development (ACTD), International Medical Corps (IMC), MoPH	RMNCH services to 33,875, living in 33 villages and settlements in three districts of Herat (Farsi, Obe, Chishti-e-Sharif).
ITA29 (Italy)	UNFPA	Agency for Assistance and Development of Afghanistan (AADA), MoPH	Providing health services in remote and underserved villages areas of Ghor provinces through 7 FHHs in Herat and 15 FHHs
CAA67 (Canada)	UNFPA	MOVE, MoPH	Essential reproductive, maternal, newborn and child health (RMNCH) services and promoting women's empowerment through family health houses in Daikundi province
FPA90	UNFPA	AADA, AMA, MOVE	Reproductive, maternal, newborn and child and adolescent (RMNCAH) health services through FHHs to women and children in Faryab provinces. Support to Nangarhar Obstetric Fistula Ward and OF Patients immediate Expenditures in Nangarhar MoPH

Strategic plan outcome: (descriptions as per CPD):

SP Outcome 1*: Increased availability and use of integrated 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.*

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

UNDAF Outcome 2: Basic Social Services: *All Afghans, especially the most marginalized and vulnerable, have equitable access to and use of quality health, nutrition, education, WASH, prevention and protection services that are appropriate and effectively address their rights and needs.*

Country programme output: (descriptions as per CPD)

Output 3: Increased national capacity to provide Reproductive health services in humanitarian settings

Atlas project (code and name)			
HFA25 (UNOCHA)	UNFPA	ACTD, HEWAD, MoPH	RH services to pregnant women and women of reproductive age to emergency obstetric and newborn care services in Helmand, Paktia, Paktika, Khost, Daikundi, Bamyan, Badakhshan and Nimroz provinces
UOE53 (Central Emergency Response Fund "CERF")	UNFPA	MoPH	RH services to women of childbearing age in Khost and Paktika provinces
UOF06 (Central Emergency Response Fund "CERF")	UNFPA	MoPH	RH services to CBA women in Kunar and Nuristan provinces
UOF18 (Central Emergency Response Fund "CERF")	UNFPA	International Medical Corps (IMC), MoPH	Trauma care services, rehabilitation, and reproductive health services to girls, boys, women, and men in Kunduz and three neighboring provinces.
UOF68 (Central Emergency Response Fund "CERF")	UNFPA	Agency for Assistance and Development of Afghanistan (AADA), Afghan Red Crescent Society (ARCS), MoPH	Life-saving critical reproductive health interventions to 69,352 (girls, boys, women, and men) at Torkham Border (Zero points) and IOM transit center
HFA64 (UNOCHA)	UNFPA	Afghan Red Crescent Society (ARCS), MoPH	Increase use of emergency lifesaving RH services by women of CBA including pregnant women who live in the 14 districts of Nangarhar, Helmand, Kandahar, Paktika, Kunduz, and Faryab provinces
WFP01 (WFP)	UNFPA	Afghan Red Crescent Society (ARCS), IMC, AADA, and HNTPO, MoPH	Provide access to integrated Reproductive health and gender-based violence information women, men and girls among IDP, returnee and host communities receiving WFP food and nutrition assistance in Kabul and Nangarhar provinces
AUA85	UNFPA	HNTPO, AADA, MOVE, HEWAD, ARCS, MoPH, AIHRC	Addressing the life-saving Reproductive Health needs of returnees displaced Afghans and host communities (particularly women and girls) in Kabul, Nangarhar, Kunar and Laghman provinces in Afghanistan
ITA38 (Italy)	UNFPA	HEWAD, MOVE, MoPH	Response to immediate Reproductive Health and GBV prevention and response needs of returnees, IDPs and host communities of

			Nimruz, Herat, Kunduz, Baghlan and Kandahar provinces
FPA90	UNFPA	ARCS, MoPH	Management support to midwives mobile health teams to provide RH services to childbearing age women in crisis-affected areas. MoPH
ADOLESCENTS AND YOUTH			
Strategic plan outcome: (descriptions as per CPD): ***SP Outcome 2****: Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased the availability of comprehensive sexuality education and Reproductive health.* ***UNDAF Outcome 2: Basic Social Services:*** *All Afghans, especially the most marginalized and vulnerable, have equitable access to and use of quality health, nutrition, education, WASH, prevention and protection services that are appropriate and effectively address their rights and needs.*			
Country programme output: (descriptions as per CPD) **Output 4:** Increased national capacity to conduct evidence- based advocacy for incorporating the rights and needs of adolescents and youth in national laws, policies and programmes, in particular healthy family life education and youth-friendly services			
Atlas project (code and name)			
FPA90	UNFPA	AFGA, DMOYA, AADA, MoPH	Capacity building program for policy and planning director of DMOYA. Establish 6 youth-friendly corners in Kabul, Kandahar, Mazar, Jalalabad
EUB06 (EU)	UNFPA	Afghan Family Guidance Association (AFGA), Agency for Assistance and Development of Afghanistan (AADA), MoPH	Increasing demand for FP; engaging men and boys in FP services, and equipping young Afghans with the necessary skills and knowledge to empower them to make informed, safe choices regarding FP in Badakhshan, Samangan, Kunar, Nangarhar, and Laghman provinces
AUA85	UNFPA	HNTPO, AADA, MOVE, HEWAD, ARCS, MoPH, AIHRC	Addressing the life-saving Reproductive Health needs of returnees displaced Afghans and host communities (particularly women and girls) in Kabul, Nangarhar, Kunar and Laghman provinces in Afghanistan
GENDER QUALITY			

Strategic plan outcome: (descriptions as per CPD):

SP Outcome 3*: Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth.*

UNDAF Outcome 3: Social Equity and Investment in Human Capital: *Social equity of women, youth, minorities and vulnerable populations is increased through the Government's improved and consistent application of principles of inclusion in implementing existing and creating new policies and legislation.*

UNDAF Outcome 3: Justice and Rule of Law: *Trust in and access to fair, effective, and accountable rule of law services is increased in accordance with applicable international human rights standards and the Government's legal obligations.*

Country programme output: (descriptions as per CPD):

Output 5: Strengthened capacities of the health sector, and law- enforcement bodies for the prevention, response and monitoring of gender-based violence and child marriage in targeted provinces

Atlas project (code and name)

UKB12 (DFID)	UNFPA	IMC, HNTPO, MOVE, AADA, HEWAD, MoPH, MoWA, MoI	Increasing Access to Gender-Based Violence (GBV) response services in Laghman, Parwan, Kapisa, Daikundi, Farah, and Jawzjan provinces
KRA07 (Korea)	UNFPA	IMC, HNTPO, HEWAD, MoPH, MoWA, MoI	Multi-sectoral Response to Gender-Based Violence through the integration of professional assistance and referral services into the health sector in Kabul, Baghlan, Nangarhar, Balkh and Bamyan Provinces
ITA38 (Italy)	UNFPA	HEWAD, MOVE, MoPH	Response to immediate Reproductive Health and GBV prevention and response needs of returnees, IDPs and host communities of Nimruz, Herat, Kunduz, Baghlan and Kandahar provinces
AUA61 (DFAT)		HEWAD, MoI	Strengthening the capacity of Afghanistan's National Police Force and other legal actors towards combating violence against women and girls" in 16 provinces of Afghanistan
AUA92 (DFAT)	UNFPA	HEWAD, MoI	Strengthening the capacity of Afghanistan's National Police Force and other legal actors towards combating violence against women and girls" in 26 provinces of Afghanistan
ITA32 (Italy)	UNFPA	HEWAD, MoPH	Increase access to life-saving RH and GBV prevention and response services for 100,000 women, girls, boys and men from returnee, IDP and host communities in affected populations concentrated in Baghlan,

			Kunduz, Herat, and Nimruz provinces and to create a safe and non-violent environment for the women and girls of Afghanistan
KRA23 (Korea)	UNFPA	IMC, HNTPO, MOVE, AADA, HEWAD, MoPH, MoWA	Increasing Access to GBV Response Services: Implementing the GBV Health Sector Response Model in Nangarhar, Kabul, Balkh, Bamyan, Baghlan, Samangan, Ghor, Faryab, Khost, Paktya and Badghis provinces
AUA85	UNFPA	HNTPO, AADA, MOVE, HEWAD, ARCS, MoPH, AIHRC	Addressing the life-saving Reproductive Health needs of returnees, displaced Afghans and host communities (particularly women and girls) in Kabul, Nangarhar, Kunar and Laghman provinces in Afghanistan
UKB37 (DFID)	UNFPA	IMC, HNTPO, MOVE, HEWAD, MoPH, MoWA	Increasing Access to GBV Response Services in Afghanistan: Implementing the GBV Health Sector Response Model in Daikundi, Farah, Jawzjan, Laghman, Kapisa, and Parwan provinces
CAA38 (Canada)	UNFPA	HEWAD, IMC, MoWA, MoPH	Addressing violence against women and girls for the internally displaced person in Nangarhar province
ITA22 (Italy)	UNFPA	IMC, MoPH, MoWA	Creating safe and non-violent environments for women and girls in Herat province
JPA32 (Japan)	UNFPA	HEWAD, NSIA	Strengthening the capacity of Afghanistan's National Police Force and other legal actors towards combating violence against women and girls" in seven provinces of Afghanistan. The project was implemented in the provinces of Herat, Balkh, Badghis, Farah, Faryab, Jawzjan and Ghor with the generous support of the Government of Japan through its embassy in Afghanistan
UKA96 (DFID)	UNFPA	HNTPO, MoWA	Increase access and utilization of GBV response services in six provinces of Afghanistan: Daikundi, Farah, Jawzjan, Laghman, Panjsher, and Parwan
UOF19 Central Emergency Response Fund "CERF")	UNFPA	MoPH, MoWA	Provision of life-saving multi-sectoral services for gender-based violence to 8,635 GBV survivors in Kunduz province.
FPA90	UNFPA	HEWAD, MoWA, MoI	Technical assistance to the ministry of women affairs and ministry of interior affairs

POPULATION DYNAMICS

Strategic plan outcome: (descriptions as per CPD):

SP Outcome 4*: Strengthened national policies and international development agendas through the integration of evidence-based analysis on population dynamics and their links to sustainable development, Reproductive health and reproductive rights, HIV and gender equality*.

UNDAF Outcome 5: Accountable Governance*: Improved legitimate, transparent and inclusive governance at all levels that enables progressive realization of human right*

Country program output: (descriptions as per CPD)

Output 6: Increased availability of national and local data, disaggregated by sex and age, to formulate, implement and monitor policies and programs

Output 7: Increased capacity of government counterparts, parliamentarians and academic institutions, in data utilization and advocacy for policy development, planning, and monitoring of programmes on youth, gender equality and reproductive health.

Atlas project (code and name)

USA43 (USAID)	UNFPA	HEWAD, NSIA	Conduct Socio-Demographic and Economic Survey in Herat, Nimroz, Baghlan and Badghis Provinces
UKA94 (DFID)	UNFPA	HEWAD, NSIA	Conduct the SDES in the provinces of Balkh, Kabul, Samangan and Takhar provinces Government of Afghanistan Policymakers
UDA38 (UNDP)	UNFPA	Worldpop-Flowminder NSIA	Government of Afghanistan and other Policymakers
JPA22 (Japan)	UNFPA	NSIA	Socio-Demographic and Economic Survey in Ghor, Daikundi, Parwan, and Kapisa Government of Afghanistan and other Policymakers
UKA78 (DFID)	UNFPA	NSIA	Socio-Demographic and Economic Survey in Kabul and Samangan Government of Afghanistan and other Policymakers
FPA90	UNFPA	HEWAD, MoPH	Hire a consultant to provide technical assistance to Kabul university to review resources materials for a course on demography and

			population studies, provide technical assistant to MoPH for implementation of CRVs strategy MoPH and Kabul University