Volume 1.

Final Cluster Evaluation Report for the UNFPA Programmes in Bosnia and Herzegovina, North Macedonia, Serbia and Kosovo[1]

Area covered by this evaluation[2]

Mr. Sam Clark,International Consultant/Cluster Evaluation Team Leader

December 2019

[1] References to Kosovo shall be understood to be in the context of Security Council resolution 1244 (1999)

[2] The map is for illustration purpose only and do not imply the expression of any opinion whatsoever on the part of the United Nations Population Fund concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

EXECUTIVE SUMMARY

Overview: UNFPA has a presence in Bosnia and Herzegovina, North Macedonia, Serbia and Kosovo forming one of the administrative clusters of the Eastern Europe and Central Asia region. The programmes of these offices have a harmonized programme cycle ending in 2020, and therefore the Cluster Programme Evaluation of all four programmes is part of the UNFPA quadrennial evaluation plan (DP/FPA/2018/1) approved by the Executive Board. The combination of the four UNFPA programmes that form one administrative cluster permits the identification of common higher-level findings that can inform future UNFPA activities. The overall purpose of the Cluster Programme Evaluation is to: a) demonstrate accountability to stakeholders on performance in achieving development results and on invested resources, b) support evidence-based decision-making, and c) contribute important lessons learned to the existing knowledge base on how to accelerate the implementation of the International Conference on Population and Development (ICPD) Programme of Action. The overall objectives of this Cluster Programme Evaluation are to achieve: (i) an enhanced accountability of UNFPA and its offices for the relevance and performance of their programmes and (ii) a broadened evidence-base for the design of the next programming cycle. The specific objectives of this evaluation are to: provide an independent assessment of the progress of each programme towards the expected outputs and outcomes set forth in the results framework of the respective programmes; provide an assessment of each offices positioning within the developing community and national partners, in view of its ability to respond to national priority needs while adding value to the development result; and to draw key lessons from past and current cooperation and provide a set of clear, specific and action-oriented strategic recommendations for the next programming cycle.

Scope of the evaluation: The evaluation (see the country/territory case studies provided in the attachments) covers all activities planned and/or implemented during these periods: Bosnia and Herzegovina 2013-2018, North Macedonia 2012-2018, Serbia 2013-2018, and Kosovo 2013-2018. Within each country/territory, the following programme components are addressed: sexual and reproductive health and rights, adolescents and youth, gender equality, population dynamics and areas of humanitarian response. In addition, three cross-cutting areas are considered: partnerships, resource mobilization, and communication. The Cluster Programme Evaluation assesses the achievements of UNFPA against expected results at the output and outcome levels, its compliance with the UNFPA Strategic Plans for 2014-2017 and 2018-2021, the UN Development Framework, and national development priorities and needs. The evaluation examines the programmes for critical features of relevance, effectiveness, efficiency, sustainability, UN coordination, and added value. The evaluation applies appropriate methodologies, including the UNEG Handbook for Conducting Evaluations of Normative Work in the UN System. The primary users of this evaluation are the decision-makers in cluster countries/territory where UNFPA operates, including the UNFPA as a whole, government counterparts, and other development partners. The UNFPA Regional Office for Eastern Europe and Central Asia and UNFPA Headquarters divisions, branches and offices will also use the evaluation as an objective basis for programme performance review and decision-making.

Description of the Country Programmes: The four UNFPA country programs were developed and implemented within the context of the respective country UNDAFs, which were guided by the goals and targets of the Millennium Declaration, as endorsed by the four national governments. For the details of these programs, see the four attached Cluster Program Evaluations for each of the countries in annex section.

Evaluation Approach: The Cluster Program Evaluation follows the approach mandated by the UNFPA Handbook (UNFPA October 2013) to assess the four CPs in two separate components. First, is an analysis of the UNFPA CP Outcomes and Outputs within the four focus areas (RHR, Youth, Gender and PD). This component employs four main criteria: relevance, effectiveness, efficiency, and sustainability. The second component assesses the positioning of the UNFPA CP within the countries based on two criteria: UNCT coordination (with the development priorities of the four countries, their collaboration within the UNDAF and other development agencies), and value added (comparative strengths in the country). The evaluation covers the six-year CP period (2014 to date). It focuses on

the outputs and outcomes within the CP Results and Resources Frameworks that was updated in 2014 to be aligned with the UNFPA Mid Term Strategic Plan (MTSP) for 2014-2017, and 2018-2000, as well as the framework for the respective country UNDAFs.

Methodology: The evaluation was conducted by four National evaluation teams with support of an international evaluation team leader. The four national evaluation teams consisted of a National evaluation consultant with a National evaluation assistant (The Kosovo team had an additional expert in reproductive health). All countries followed the same methodology, however country teams adjusted evaluation tools. The evaluation was conducted in two phases: 1) initial preparations for the development of a Design Report following a full-team meeting in Montenegro, Oct 21-27, 2018; 2) the four country evaluations were carried out by the national evaluation teams at different times during in 2018 and 2019. The evaluation is based on non-random samples of respondents with qualitative data collection methods. All interviews followed informed consent procedures as required by the UN Evaluation Group's norms and standards. The collection of evaluation data was implemented using five main methods: 1) Desk review 2) Site visits to CP targeted areas in various regions 3) Semi- structured group and individual interviews with stakeholders 4) Group and individual follow-up interviews with former trainees in UNFPA-supported training events 5) Focus group discussions (FGDs) and exit interviews with stakeholders and client/beneficiaries. The analysis is based on a synthesis and triangulation of information obtained from the above-mentioned evaluation activities. Limitations of the evaluation include its non-representative, qualitative nature due to small, non-random samples and low response rates for certain interview categories. All interviews were done without the presence of UNFPA staff.

Key Findings Overview - Relevance: For each of the four countries, there was evidence of relevance for all four program areas, which were consistent with national strategies and the needs of implementing partners and beneficiaries. The four program area activities were developed on the basis of assessments, nationally representative data and consultation with stakeholders and beneficiaries and were consistent with UNFPA global strategy, ICPD Program of Action, Millennium Development Goals and the UNDAF. **Effectiveness:** For each of the four countries**,** all four program areas achieved or are on track to meet most of their output targets and have made significant progress toward achievement of their respective outcomes. **Efficiency:** For each of the four countries the programme activities implemented toward the achievement of outputs for all program areas appear to be reasonable for the amount of resources expended. Most respondents felt that the CPs have been careful to manage their funds efficiently and have achieved a great deal with a limited budget and staff. **Sustainability:** Among the four countries, while some activities were clearly not sustainable without continued donor support, there were concrete examples of sustainable results for all program areas. **United Nations Country Team Coordination**: There was strong evidence of active and effective UNCT collaboration among all four country programmes. UNFPA COs contribute to the functioning and consolidation of the national UNCT programme mandates. **Added Value:** UNFPA COs have long-term ties to national counterparts, are reliable partners for all four program areas and are effective policy advocates. The four country programmes were also assessed in the context of the **three UNFPA transformative goals** and progress toward developing updated **strategies to address relevant SDGs.** Three cross-cutting areas (**partnerships, resource mobilization, and communication**) were reviewed for each country.

Cluster Evaluation Conclusions - Strategic Conclusion 1: All four UNFPA programmes currently focus on too many outputs, many of which are focused outside the key interventions within UNFPA's core mandate. There is a clear need to reduce the number of activities to improve focus and efficacy. **SRH Related Conclusions** In all four countries/territory, **1:** there are ongoing problems with family planning service delivery, including a low prevalence of use of modern contraceptives, lack of accessibility and availability of contraceptives and a high reliance on abortion. **2:** there is need for a more comprehensive UNFPA programmatic response for vulnerable population groups: Roma, people with disabilities and adolescent girls. **3:** there has been some interest on the part of UNFPA in addressing cervical cancer, with the most significant progress made in Kosovo. **4:** despite improvements in levels

of maternal mortality and morbidity, trends in these measures are not consistently monitored over time to ensure progress continues to be achieved. **5:** UNFPA has demonstrated considerable progress in implementing the Minimum Initial Service Package (MISP) programme, especially in the context of the health sector response to emergencies and GBV. **Cluster Adolescence and Youth Related Conclusions** In all four countries/territory, **1:** the importance of expanding comprehensive sexuality education (CSE) in primary schools and high schools is very high. **2:** the role of men in achieving gender equality and zero tolerance to gender-based violence is considered important, and programmes have successfully involved young men and boys to improve SRH and address GE and GBV. **3:** awareness among youth on SRHR issues is low and UNFPA has only made limited efforts to address this gap. Raising awareness about SRHR among youth could be achieved through development and use of applications for mobile phones. **GE and GBV Related Conclusions:** In all four countries/territory**, 1:** the UNFPA GE programme area has been mostly aligned with international and national policy frameworks and has been able to adapt to local context; the CPs have been adapted largely to the needs of women, including some groups of marginalized and vulnerable women, more specifically victims of GBV and CRSV. Service providers' capacities and competencies to deal with GBV have been significantly improved. **Population and Development Related Conclusions** In all four countries/territory, **1:** national population data with improved quality are needed to allow development planning and to address the needs of marginalized and vulnerable populations for the allocation of resources and programmes; and **2:** essential current demographic data are missing to serve as evidence for future policy development.

Cluster Evaluation Recommendations - Strategic Recommendation 1: (Priority: High) All four UNFPA programmes should focus on fewer outputs that are focused on interventions within UNFPA's core mandates in order to get efficiency gains. It is recommended that UNFPA programmes in the four countries/territory focus primarily on two areas: SRHR and PD, both of which are well within UNFPA traditional mandate and do not overlap with other UN agencies. These two programme focus categories should be kept narrow in focus but can address specific target groups and focus areas, such as youth, marginalized populations, and women victims of GBV. **Cluster SRHR Recommendations** All four countries/territory should **1:** (Priority: High) continue and expand to work on family planning service delivery to reduce unmet need and reliance on abortions for unplanned pregnancy. **2:** (Priority: High) adjust interventions to the needs of specific marginalized and vulnerable groups (Roma, people with disabilities and young adolescent girls). **3:** (Priority: Medium) focus on developing and supporting an economical approach for cervical cancer screening and treatment that can be gradually expanded to serve all parts of each country/territory. **4:** (Priority: Low) support work related to maternal health, and in particular work on maternal mortality and morbidity surveillance.**5**: (Priority: Medium) support work related to MISP to ensure that it is fully functional in time of need within each country's response system for health emergencies. **Cluster Adolescence and Youth Recommendations** In all four countries/territory UNFPA programmes should **1:** (Priority: High) support efforts to work within public primary and high schools to support the development of effective CSE curricula and training of appropriate types and quantity of teachers for expansion of CSE in cooperation with national educational systems. **2:** (Priority: Medium) implement programmes that address SRH, gender stereotypes and GBV among young men and scale up these programmes as much as feasible. **3:** (Priority: Medium) develop or assist government institutions and NGO organizations to develop and maintain of a mobile phone application for SRHR targeting youth. **Cluster GE and GBV Recommendation** UNFPA programmes in all four countries/territory should **1:** (Priority: Medium) remain active in the field of GE and GBV by supporting capacity building of health professionals through future UNFPA supported SRH initiatives. **Cluster Population and Development Recommendations**: In all four countries/territory the UNFPA programme should **1:** (Priority: High) continue to extend advisory support to the national partners, notably the national agencies responsible for statistics, to enhance knowledge and the instruments for collection and dissemination of data relevant for improved national population statistics. **2:** (Priority: High) support and participate in the MICS6 activities (or in the case of BiH, consider providing support for a DHS or other survey).

Structure of the Cluster Evaluation Report

This report is made up of five volumes. Volume 1: Cluster Evaluation Report provides a synthesis of all country reports with cluster-level analysis and common themes in all countries. Volumes 2 through 5 are the country reports for Bosnia and Herzegovina, North Macedonia, Serbia and Kosovo.

The Evaluation Team

1. Mr. Sam Clark, International Consultant/Cluster Evaluation Team Leader
2. Ms. Nina Karadjinovic, National Evaluator and Team leader, Bosnia and Herzegovina
3. Ms. Rajna Cemerska, National Evaluator and Team leader, North Macedonia
4. Ms. Bosiljka Djikanovic, National Evaluator and Team leader, The Republic of Serbia
5. Mr. Levent Koro, National Evaluator and Team Leader, Kosovo
6. Mr. Sami Uka, National Evaluator and Team Member, Kosovo
7. Ms. Sanela Muharemovic, Research Assistant, Bosnia and Herzegovina
8. Ms. Sara Osmani, Research Assistant, North Macedonia
9. Ms. Zeljka Stamenkovic, Research Assistant, The Republic of Serbia
10. Mr. Alban Fejza, Research Assistant, Kosovo

ACNKOWLEDGEMENTS

The authors wish to acknowledge with sincere thanks the many staff members from the various Ministries and related institutions, the UN collaborating Agencies, development partner agencies and a wide range of NGOs in BiH, North Macedonia, Serbia and Kosovo for providing time, resources and materials to permit the development and implementation of this evaluation. We appreciate the participation of members of the Evaluation Reference Groups in the four countries, especially those, who took time to attend briefings and provided comments. We are particularly grateful to the UNFPA staff members in the four countries, who, despite a very heavy load of other pressing commitments, were so responsive to our repeated requests, often on short notice. We would also like to acknowledge the many other stakeholders and client/beneficiaries and the dedicated staff at the primary health care level in the four countries, who helped the implementation of this evaluation despite their busy schedules. It is the team's hope that this evaluation and recommendations presented in this report will contribute to a firm foundation for future UNFPA supported programs in collaboration with the Governments of BiH, North Macedonia, Serbia and Kosovo. The oversight of UNFPA's evaluation office is gratefully acknowledged, in particular the contributions of Mr. Mahbub Alam. Finally, we would like to acknowledge the extremely patient, astute and energetic assistance of Mr. Zeljko Blagojevic - CO BiH PD/M&E Programme Analyst, who provided tremendous technical and administrative support for the entire evaluation.

LIST OF ABREVIATIONS

AoR	**Area of Responsibility**
AR	**Assistant Representative**
AWP	**Annual Work Plan**
BD	**Brcko District of Bosnia and Herzegovina**
BiH	**Bosnia and Herzegovina**
BTN	**Beyond the Numbers**
CDP	**Common Development Plan**
CEDAW	**Committee on the Elimination of Discrimination against Women**
CO	**Country Office**
CP	**Country Program**
CPD	**Country Program Document**
CPE	**Country Program Evaluation**
COAR	**Country Office Annual Report**
CSE	**Comprehensive Sexuality Education**
Est.	**Estimated**
EC	**European Commission**
EM	**Evaluation Manager**
EPC	**Effective Perinatal Care**
EU	**European Union**
EUCEP	**European Union Technical Assistance Project in Kosovo**
FBiH	**Federation of Bosnia and Herzegovina**
FGDs	**Focus Group Discussions**
GBV	**Gender-Based Violence**
GDP	**Gross Domestic Product**
GEWE	**Gender Equality and Women's Empowerment**
GNI	**Gross National Income**
GPI	**Gender Parity Index**
HBSC	**Health Behaviour in School-aged Children**
HDI	**Human Development Index**
HFA	**Health For All (Family of Databases)**
HIV/AIDS	**Human Immunodeficiency Virus/ Acquired Immuno-Deficiency Syndrome**
ICPD	**International Conference on Population and Development**
MDGs	**Millennium Development Goals**
MISP	**Minimum Initial Service Package**
MNCRH	**Maternal, Neonatal, Child and Reproductive Health**
MICS	**Multiple Indicator Cluster Survey**
MP	**Member of Parliament**
M&E	**Monitoring and Evaluation**
NATO	**North-Atlantic Treaty Organisation**
NCD	**Non-Communicable Diseases**
NE	**National Evaluator**
ODA	**Official Development Assistance**
OECD	**Organisation for Economic Co-operation and Development**
PCA	**Programme Coordination and Assistance**
PD	**Population Dynamics/Development**
PwD	**Persons with Disabilities**
SRHR	**Sexual and Reproductive Health and Rights**
RA	**Research Assistant**
RS	**Republika Srpska**
SAK/KAS	**Statistical Agency of Kosovo**
SDGs	**Sustainable Development Goals**
SFR	**SFR of Yugoslavia**
SMEs	**Small and Medium Enterprises**
SRH	**Sexual and Reproductive Health**
STDs/STIs	**Sexually Transmitted Diseases/Sexually Transmitted Infections**
TFR	**Total Fertility Rate**

ToR **Terms of Reference**
ToT **Training of Trainers**
UNAIDS **The Joint United Nations Programme on HIV/AIDS**
UNCT **United Nations Country Team**
UNDAF **United Nations Development Assistance Framework**
UNDPF **United Nations Development Partnership Framework**
UNDP **United Nations Development Programme**
UNEG **United Nations Evaluation Group**
UNESCO **United Nations Educational, Scientific and Cultural Organisation**
UNFPA **United Nations Population Fund**
UNHCR **United Nations High Commissioner for Refugees**
UNICEF **United Nations International Children's Emergency Fund**
UNOPS **United Nations Office for Project Services**
UNKT **United Nations Kosovo Team**
UNSC **United Nations Security Council**
UNSCR 1244 **United Nations Security Council Resolution 1244**
UN-Women **The United Nations Entity for Gender Equality and the Empowerment of Women**
WB **World Bank**
WHO **World Health Organisation**

Key Facts Table for Bosnia and Herzegovina, Northern Macedonia, Serbia and Kosovo

Land	Bosnia and Herzegovina	Northern Macedonia	Serbia	Kosovo
Geographic location	Bosnia and Herzegovina is located in South-Eastern Europe and is a part of the geo-political region known as the Western Balkans. It borders Serbia in the east, Montenegro in the south-east and Croatia in the north and west, with a short coastline on the Adriatic Sea in the south-west.	Northern Macedonia is a country in the Balkan peninsula in Southeast Europe. It is bordered by Serbia to the north, Kosovo to the northwest, Bulgaria to the east, Greece to the south, and Albania to the west.	Serbia is a landlocked country situated in southeastern Europe, in the centre of the Balkan Peninsula. Because Serbia covers part of the Pannonian Plain in the north, the country also belongs to Central Europe. It shares borders with Bosnia-Herzegovina, Bulgaria, Croatia, Hungary, Northern Montenegro, Romania and Albania through the disputed territory of Kosovo.	Kosovo is a landlocked country located in south-east Europe. It is bordered by Serbia to the north, The former Yugoslav Republic of Macedonia to the south, Montenegro to the east, and Albania to the south-east.
Total area	51,197 km^2	25,713 km[1]	87,460 km^2	10,908km^3
Terrain	The terrain of Bosnia and Herzegovina is predominantly mountainous, with an average elevation of 500m and a number of peaks over 2,000m. At 2,386m above sea level, Mt Maglic is the country's highest peak, situated in the south-east. The lowland area Posavina is in the north. This rugged terrain is home to diverse natural resources and a factor of Bosnia and Herzegovina's biodiversity, with the majority of inland mountains covered by forest. Notably, Bosnia and Herzegovina is criss-crossed with several watersheds, providing water supply to population and industry and representing a strong hydro-power potential.	The country is a landlocked country that is geographically clearly defined by a central valley formed by the Vardar river (the lowest point of the country) and framed along its borders by mountain ranges. The terrain is mostly rugged, especially the part that frame the valley of the Vardar river. Three large lakes – Lake Ohrid, Lake Prespa and Dojran Lake – lie on the southern borders, bisected by the frontiers with Albania and Greece. The region is seismically active and has been the site of destructive earthquakes in the past, most recently in 1963 when Skopje was heavily damaged by a major earthquake, killing over 1,000. The country also has scenic mountains which belong to two different mountain ranges. Mount Korab (the highest point of the country), is the tallest mountain (2,764 m).[4]	Serbia's terrain ranges from rich, fertile plains of the northern Vojvodina region, limestone ranges and basins in the east, and in the southeast ancient mountains and hills. The north is dominated by the Danube River. The main communication and development line stretches southeast of Belgrade, along the valley of Great and South Morava river. Most major cities are located on or around that line, as well as the main railroad and highway. The highest mountains of that area are Zlatibor and Kopaonik.	The most noticeable topographical features are the Bjeshkët e Nemuna and the Sharr Mountains. The Bjeshkët e Nemuna mountain range, also known as the Albanian Alps are a geological continuation of the Dinaric Alps. The mountains run laterally through the west along the border with Albania and Montenegro. The southeast is predominantly the Sharr Mountains, which form the border with the former Yugoslav Republic of Macedonia. Besides the mountain ranges, the territory of Kosovo consists mostly of two major plains: the Kosovo Plain in the east and the Dukagjini plain in the west.

[3] (Wikipedia, 2018) https://en.wikipedia.org/wiki/Kosovo
[4] https://en.wikipedia.org/wiki/Macedonia

People	Bosnia and Herzegovina	Northern Macedonia	Serbia	Kosovo
Population as of 2013 in thousands	3,531,159[i5]	2,103,721 [1]	7.020.858 [1]	1,78 million [6]
Urban population 2013 in thousands	1,506,691 (42,7 %)[ii]	58% of total population [1]	55.94 [2]	Prishtina (capital)[7]
Natural Increase Rate in 2016	-1,8%[iii]	NA	NA	NA
Population Growth Rate (2017)	-0.3%[xxii]	0.17% [1]	-0.51% [3]	0.8%.
Government				
Government	Parliamentary republic	Republic	Republic	Republic
% of seats held by women in parliament (2014)	19.9%[iv]	34.20% in 2017 [2]	37.6% [4]	32.5% of the parliament consists of women [8]
Economy				
GDP per capita PPP US$ in 2017 (est.)	$12,875.97[v]	$14,900 [1]	$15.090 [5]	3.566[9] in Euros 2017
GDP Real Growth rate in 2015 (est.)	3.37%[vi]	2,9% [1]	1.867% [6]	4.2%[10] in 2017
Main industries	Mining (coal, steel, iron ore, bauxite), metal processing, timber	Food processing, beverages, textiles, chemicals, iron, steel, cement, energy, pharmaceuticals, automotive parts. [1]	Automotive, mining, non-ferrous metals	Minerals and metals production - and a variety of construction materials
Social indicators				
Distribution of Family Income - Gini Index in 2011	33.8[11] Rank 107 out of 157 nations.	33.7; Rank 115 out of 157 nations (ref 4)	38.7; Rank 75 out of 157 nations	23.2 [12] Rank 155 out of 157 nations.
Human Development Index Rank (2018)	0.768[vii]	Index 0.757 Rank 80 (2017) (Ref 3)	Index 0.787 ; Rank 67	Index 0.741 (2016)[13]
Unemployment	20.5%[viii]	23% (Ref 3)	14.10% 2018	29.4%[14]
Life expectancy at birth 2015-2020 (est.)	77 years [ix]	76.4 years (2017)	75.3	71.65 years[15]
Health expenditure (% of GDP) in 2016	9.2%[x]	6.5% [1]	9.9	2.32[16]

[5] The 2013 Census Report, although officially recognized by the BiH Agency for Statistics and the FBiH Institute for Statistics, as well as by the members of the International Monitoring Missions (including Eurostat, UNFPA, UNSD and UNECE), has been disputed by the RS Institute for Statistics over the methodology used for data processing. The RS Institute for Statistics has developed own Census report that is in use in this entity. There has been no agreement between government institutions on how this issue will be solved.

[6] (ASK, 2016) http://ask.rks-gov.net/media/3672/kos-in-figures-2016.pdf

[7] (CIA, 2018) https://www.cia.gov/library/publications/the-world-factbook/geos/kv.html

[8] (Gap Institute, 2017) http://www.institutigap.org/documents/31876_Gap%20analiza_perberja%20gjinore%20e%20bordeve.pdf

[9] (Kosovo Statistical Office, 2018) http://ask.rks-gov.net/media/4333/gross-domestic-product-gdp-production-approach-2017.pdf

[10] (Kosovo Statistical Office, 2018) http://ask.rks-gov.net/media/4333/gross-domestic-product-gdp-production-approach-2017.pdf

[11] CIA the World Factbook. December 2018. //www.cia.gov/library/publications/the-world-factbook/rankorder/2172rank.html

[12] (CIA, World Factbook https://www.cia.gov/library/publications/the-world-factbook/geos/mk.html. 2018)

[13] (UNDP, 2016) http://hdr.undp.org/sites/default/files/human_development_report_2016.pdf

[14] (KAS, 2018) http://ask.rks-gov.net/en/kosovo-agency-of-statistics/add-news/labor-force-survey-in-kosovo-q2-2018

[15] (World Bank, 2018) https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=XK&view=chart

[16] (MCC, 2018) https://www.mcc.gov/who-we-fund/scorecard/fy-2016/XK

Contraceptive prevalence (% of women ages 15-49) in 2012	45.8%[xi]	40.2% [5]	18.4% modern methods;40% traditional	12.3%[17]
Unmet need for family planning in 2012	19% of married women 15-49[xii]	17.2% [3]	23% of currently married or in union	10.8%[18]
% of people living with HIV, 15-49 years old in 2014	NA	0.10% [6]	0.10	NA (97 cases[19])
Adult literacy (% aged 15 and above) in 2013	96.99%[xiii]	97.8% [7] in 2015 est.	98.84%	NA
Net enrolment rate (primary) in 2011	97.6%[xiv]	94.0% [3] in 2018	100.31	NA

[i] Agency for Statistics of Bosnia and Herzegovina. (n.d.). Retrieved from Popis 2013 u BiH: www.statistika.ba

[ii] Agency for Statistics of Bosnia and Herzegovina. (n.d.). Retrieved from Popis 2013 u BiH: www.statistika.ba

[iii] Agency for Statistics of Bosnia and Herzegovina. (2018). *Demography and Social Statistics. World Population Day.* Sarajevo: Agency for Statistics of Bosnia and Herzegovina. Retrieved from http://bhas.ba/saopstenja/2018/DEM_03_2018_Y1_0_BS.pdf

[iv] Miftari, E. (2015). *Politička participacija žena u Bosni i Hercegovini: Analiza učešća žena na stranačkim listama i konačnih rezultata općih izbora 2014.* Sarajevo: Fondacija CURE; Sarajevski otvoreni centar.

[v] The World Bank Group. (2018). *GDP per capita, PPP (current international $)*. Retrieved November 2018, from World Bank Open Data: https://data.worldbank.org/indicator/NY.GDP.PCAP.PP.CD

[vi] Agency for Statistics of Bosnia and Herzegovina. (2018). *First Release. Gross Domestic Product by Expenditure Approach 2007-2017.* Sarajevo: Agency for Statistics of Bosnia and Herzegovina.

[vii] United Nations Development Programme. (2018). *Briefing note for countries on the 2018 Statistical Update: Bosnia and Herzegovina.* United Nations Development Programme. Retrieved from http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/BIH.pdf

[viii] Agency for Statistics of Bosnia and Herzegovina. (2017). *Labour Force Survey 2017.* Sarajevo: Agency for Statistics of Bosnia and Herzegovina.

[ix] United Nations. (2015). *World Population Prospects: The 2015 Revision, Key Findings and Advance Tables.* Department of Economic and Social Affairs, Population Division. New York: United Nations.

[x] Agency for Statistics of Bosnia and Herzegovina. (2018). *Demography and Social Statistics. World Population Day.* Sarajevo: Agency for Statistics of Bosnia and Herzegovina. Retrieved from http://bhas.ba/saopstenja/2018/DEM_03_2018_Y1_0_BS.pdf

[xi] Agency for Statistics of Bosnia and Herzegovina; Federal Ministry of Health; Ministry of Health and Social Welfare of the Republic of Srpska; Institute of Public Health FB&H; UNICEF . (2013). *Bosnia and Herzegovina Multiple Indicator Cluster Survey (MICS) 2011-2012.* Sarajevo: UNICEF.

[xii] Agency for Statistics of Bosnia and Herzegovina; Federal Ministry of Health; Ministry of Health and Social Welfare of the Republic of Srpska; Institute of Public Health FB&H; UNICEF. (2013). *Bosnia and Herzegovina Multiple Indicator Cluster Survey (MICS) 2011-2012.* Sarajevo: UNICEF.

[xiii] The World Bank Group. (2018). *Literacy rate, adult total (% of people ages 15 and above)*. Retrieved November 2018, from World Bank Open Data: https://data.worldbank.org/indicator/SE.ADT.LITR.ZS?locations=BA

[xiv] Agency for Statistics of Bosnia and Herzegovina; Federal Ministry of Health; Ministry of Health and Social Welfare of the Republic of Srpska; Institute of Public Health FB&H; UNICEF . (2013). *Bosnia and Herzegovina Multiple Indicator Cluster Survey (MICS) 2011-2012.* Sarajevo: UNICEF.

[17] (Trading Economics, 2018) https://tradingeconomics.com/kosovo/current-use-of-contraception-modern-method-percent-of-married-women-q1-lowest-wb-data.html

[18] (Trading Economics, 2018) https://tradingeconomics.com/kosovo/unmet-need-for-family-planning-total-percent-of-married-women-q1-lowest-wb-data.html

[19] (UNAIDS, 2015) http://www.unaids.org/sites/default/files/country/documents/KOSOVO_narrative_report_2015.pdf

[xv] WHO, UNICEF, UNFPA, World Bank Group, and the United Nations Population Division. (2015). *Trends in Maternal Mortality: 1990 to 2015.* Geneva: World Health Organization.
[xvi] The World Bank Group. (2018). *Births attended by skilled health staff (% of total)*. Retrieved from World Bank Open Data: https://data.worldbank.org/indicator/SH.STA.BRTC.ZS?locations=BA
[xvii] The World Bank Group. (2018). *Mortality rate, under-5 (per 1,000 live births)*. Retrieved November 2018, from World Bank Open Data: https://data.worldbank.org/indicator/SH.DYN.MORT?locations=BA
[xviii] Agency for Statistics of Bosnia and Herzegovina. (2017). *Sustainable Development Indicators. Bosnia and Herzegovina.* Sarajevo: Agency for Statistics of Bosnia and Herzegovina.
[xix] United Nations Development Programme. (2018). *Briefing note for countries on the 2018 Statistical Update: Bosnia and Herzegovina.* United Nations Development Programme. Retrieved from http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/BIH.pdf
[xx] Agency for Statistics of Bosnia and Herzegovina; Federal Ministry of Health; Ministry of Health and Social Welfare of the Republic of Srpska; Institute of Public Health FB&H; UNICEF . (2013). *Bosnia and Herzegovina Multiple Indicator Cluster Survey (MICS) 2011-2012.* Sarajevo: UNICEF.
[xxi] Agency for Statistics of Bosnia and Herzegovina. (2017). *Sustainable Development Indicators. Bosnia and Herzegovina.* Sarajevo: Agency for Statistics of Bosnia and Herzegovina.
[xxii] The World Bank. (n.d.). Retrieved from World DataBank: http://databank.worldbank.org/data/source/health-nutrition-and-population-statistics
[xxiii] The World Bank Group. (2018). *Mortality rate, infant (per 1,000 live births)*. Retrieved November 2018, from World Bank Open Data: https://data.worldbank.org/indicator/SP.DYN.IMRT.IN?locations=BA

Table of Contents

TABLES

FIGURES

CHAPTER 1: Introduction

1.1. Purpose and objectives for the Cluster Programme Evaluation

UNFPA has presence in Bosnia and Herzegovina, North Macedonia, Serbia and Kosovo forming one of the administrative clusters of the Eastern Europe and Central Asia region. The programmes of these offices have a harmonized programme cycle ending in 2020, and therefore the Cluster Programme Evaluation of all four programmes has been planned as part of the UNFPA quadrennial evaluation plan (DP/FPA/2018/1) approved by the Executive Board. This important aspect of the Cluster Programme Evaluation, the combination of multiple programmes together (in this case four UNFPA offices that form one administrative cluster), permits the identification of common higher-level findings that can inform future UNFPA activities. The overall purpose of the Cluster Programme Evaluation is to: a) demonstrate accountability to stakeholders on performance in achieving development results and on invested resources, b) support evidence-based decision-making, and c) contribute important lessons learned to the existing knowledge base on how to accelerate the implementation of the International Conference on Population and Development (ICPD) Programme of Action.

The overall objectives of this Cluster Programme Evaluation are to achieve: (i) an enhanced accountability of UNFPA and its offices for the relevance and performance of their programmes and (ii) a broadened evidence-base for the design of the next programming cycle. The specific objectives of this evaluation are:

- To provide an independent assessment of the progress of each programme towards the expected outputs and outcomes set forth in the results framework of the respective programmes;
- To provide an assessment of each offices positioning within the developing community and national partners, in view of its ability to respond to national priority needs while adding value to the development results.
- To draw key lessons from past and current cooperation and provide a set of clear, specific and action-oriented strategic recommendations for the next programming cycle.

1.2. Scope of the evaluation

The evaluation (including country/territory case studies) will cover all activities planned and/or implemented during the period: Bosnia and Herzegovina 2013-2018, North Macedonia 2012-2018, Serbia 2013-2018, and Kosovo 2013-2018. Within each country/territory, the following programme components are addressed: sexual and reproductive health and rights, adolescents and youth, gender equality, population dynamics and areas of humanitarian response. In addition, three cross-cutting areas are considered: partnerships, resource mobilization, and communication. The scope of the evaluation is extended beyond the current programme periods of the cluster countries/territory in order to assess achievement/non-achievement of higher level development results. This Cluster Program Evaluation was initially planned to assess the nine-year period from 2010 to 2018 for three of the four UNFPA programmes (all except for Bosnia and Herzegovina, which was set for 2013-2018). This extended time period was not pursued for two reasons: it is felt to exceed available resources and the assessment of an additional two years of UNFPA program activity is not likely to warrant the investment.

Besides the assessment of the intended effects of the programmes, the evaluation also aims at identifying potential unintended effects. The Cluster Programme Evaluation will analyse the achievements of UNFPA against expected results at the output and outcome levels, its compliance with the UNFPA Strategic Plans for 2014-2017 and 2018-2021, the UN Development Framework, and national development priorities and needs.

The evaluation reconstructs the logic of programme interventions and assesses the extent to which the ongoing programmes have chosen the best possible modalities for achieving the planned results in the current development context. The evaluation examines the programmes for such critical features as relevance, effectiveness, efficiency, sustainability, UN coordination, and added value. The evaluation applies appropriate methodologies, including the UNEG Handbook for Conducting Evaluations of Normative Work in the UN System for assessing the equity and vulnerability, gender equality, human rights in development and humanitarian programmes.

The primary users of this evaluation are the decision-makers in cluster countries/territory where UNFPA operates, including the UNFPA as a whole, government counterparts, and other development partners. The UNFPA Regional Office for Eastern Europe and Central Asia and UNFPA Headquarters divisions, branches and offices will also use the evaluation as an objective basis for programme performance review and decision-making.

1.3. Methodology and process

This evaluation is designed to review programmes using two separate evaluation components:

Component 1: Analysis of the programme's Outcomes, Outputs and activities by the four main focus areas that reflect alignment to the global UNFPA Strategic Plans 2014-2017, 2018-2021 - SRHR, Youth, GE, and PD, and

Component 2: Analysis of UNFPA office's coordination within the UN Country Team (UNCT) and among national partners in the four focus areas as well as their added value.

There are clearly defined sets of evaluation criteria for each of these two components, which are shown in the Table 1.3.1 below. In addition to the focus on the programme's Outcomes, Outputs and activities in the four main focus areas and the focus on the UNFPA office's coordination and added value, attention is focused on three plans implemented by these programmes: 1. Resource mobilization plans. 2. Partnership Plans. 3. Communications/advocacy plans. These plans are assessed using the same evaluation criteria as listed for Evaluation Component 1.

Table 1.3.1 CP Evaluation components and evaluation criteria

Evaluation Component 1	Evaluation Component 2
Analysis of programme by Focus Area	Analysis of UNFPA CO positioning within country/territory
Evaluation Criteria	Evaluation Criteria
Relevance	Coordination with the UNCT
Effectiveness	Value Added
Efficiency	
Sustainability	

1.3.1. Evaluation Questions and Evaluation Matrix

As outlined in the Cluster Evaluation Terms of Reference (TOR) in Annex 1, a set of questions has been recommended for each of the above evaluation criteria within each of the two evaluation components. These evaluation questions have been central to the conduct of the evaluation. For evaluation of three of the four programmes, with few exceptions, the original questions from the Cluster Evaluation TOR have been retained exactly as worded. The wording for some questions was revised to increase clarity while retaining the intent of the TOR. For the evaluation of programme in Kosovo, the evaluation questionnaires covered the same material but were developed using a different approach that did not use the exact text provided.

As required by the evaluation CPE handbook[20], for each of the four programmes a detailed evaluation matrix has been prepared which explains which data sources and methods have been used to address each of these questions (Evaluation Matrices are available in each of the respective country/territory programme annexes).

1.3.2. Methods for data collection and analysis

As explained above, for each of the four programmes there were slightly different timelines for the frameworks. For BiH, the frameworks for the CP (2010-2014, 2015-2019(20)) had three and four outcomes, respectively. For Serbia and Kosovo the evaluation covers parts of two frameworks, part of CP (2010-2015) and CP (2016-2020), while for North Macedonia, it covers parts of two programme frameworks CP (2010-2015) and CP (2016-2020). These frameworks were the central focus of the evaluation. Attention was given to key activities related to the outcomes and outputs, in particular, whether or not these key activities were completed satisfactorily or not.

Methods overview: The four programme evaluations used mixed methods, which were selected in order to ensure triangulation of information from different sources. The primary sources for these four PEs were: documentary sources (programme documents and assessments), stakeholder interviews, and trainee and beneficiary interviews and focus group discussions. All findings have been confirmed by at least two sources. All countries followed the same methodology, however country teams adjusted the evaluation tools. Please see the country reports in Volumes 2,3,4 and 5 for details.

The evaluation follows the principles of the UN Evaluation Group's norms and standards (in particular with regard to independence, objectiveness, impartiality and inclusiveness) and has been guided by the UN ethics guidelines for evaluators in accordance with the UNEG's Ethical Guidelines for Evaluation.[21] Evaluators were expected to operate in an impartial and unbiased manner, giving balanced interpretations of the strengths and weaknesses of programmes. They respect and protect the rights and welfare of human subjects and communities, respect differences in culture, local customs, religious beliefs and practices, personal interaction, gender roles, disability, age and ethnicity, while using evaluation instruments appropriate to diverse cultural settings. Evaluators ensured that all participants are treated as autonomous and free to choose whether or not to participate in the evaluation.

The evaluations are based on the following key activities:

1. Desk review of documents and financial and other pertinent program data
2. Interviews with stakeholders (including UN staff, national counterparts, implementing partners and development partners)
3. Training follow-up interviews with trainees in UNFPA supported training events
4. Interviews with UNFPA programme clients/beneficiaries
5. Focus group discussions (FGDs) with a limited number of small, homogeneous groups of stakeholders and beneficiaries
6. Direct observation.[22]

Stakeholder Involvement: Meetings were held with key stakeholders, in particular, the Evaluation Reference Group (ERG), which was established by each UNFPA Office comprising key programme stakeholders (governmental and non-governmental counterparts, and the Evaluation Manager from the UNFPA CO). The role of ERG was to review and provide inputs to the PE, provide feedback to the

[20] *Handbook: How to Design and Conduct a Country Programme Evaluation at UNFPA* (UNFPA Independent Evaluation Office, 2013)
[21] *UNEG Ethical Guidelines for Evaluation* (United Nations Evaluation Group, 2008)
[22] This approach was only taken by North Macedonia with field observations of UNFPA supported activities.

evaluation design report, facilitate access of evaluators to information sources, and provide comments on the main deliverables and quality of the evaluation.

Desk Review and synthesis by the Four Outcomes per Outcome/output Matrices: The Desk review was conducted for each of the programme Outcomes with an assessment of the respective outputs and activities within each Outcome. The desk review was based on the above mentioned Cluster Programme Evaluation TOR criteria.

Semi-structured interviews with stakeholders based on the Cluster Programme Evaluation TOR criteria: These interviews were conducted with a consistent set of precautions for informed consent and confidentiality. Copies of instruments are available in each of the respective country/territory annexes. Regarding the sampling, a purposive and non-random selection of key informants was made with an attempt to achieve a balance according to administrative area, focus area and female versus male respondents. In addition, key informants were selected from donor agencies and UN agencies. The number of stakeholder interviews for each of the countries/territory by focus area and gender is shown below in Table 1.3.2.1 For more details on the numbers of stakeholders interviewed by gender, see respective attachments in the respective country/territory annexes. For all four programmes combined, a total of 233 interviews, 79 training follow-up interviews and 13 FGDs were conducted.

Table 1.3.2.1 ***Number of stakeholder interviews by country/territory, focus area and gender***

	BiH			North Macedonia			Serbia			Kosovo		
	F	M	Total	F	M	Total	F	M	Total	F	M	Total
SRHR Implementers	9	4	13	23	11	34	6	0	6	20	9	29
Youth Implementers	5	2	7	11	4	15	4	1	5	10	6	16
GE Implementers	10	3	13	4	1	5	11	2	13			
PD Implementers	3	6	9	10	4	14	7	0	7	2	3	5
Total implementers	27	15	42	48	20	68	28	3	31	32	18	50
Donor Agency staff	1		1				4		4			
UN Agency staff	4	3	7	3	1	4	4	3	7	1		1
UNFPA Staff	5	2	7	4		4	3	2	5	2		2
Total UN, donor stakeholders	10	5	15	7	1	8	11	5	16	3	0	3
Total stakeholder interviews	**37**	**20**	**57**	**55**	**21**	**76**	**39**	**8**	**47**	**35**	**18**	**53**

Training Follow-up Assessment and FGDs: Participants from specific UNFPA-supported trainings were asked to respond to questionnaires and participate in FGDs (See respective country/territory annexes for methodological tools). See Table 1.3.2.2 below. With assistance of UNFPA programme and implementing partners, a database was developed for all training events sponsored by each programme in the last four years. A purposive sample of training activities was selected from this database to achieve balance on trainings conducted within the four focus areas (SRHR, Youth, GE and PD) in major training category areas. Some countries/territory did not have any trainings for PD during the timeframe of the evaluation.

Table 1.3.2.2 Training follow-up interviews by Country/Territory, Gender and focus area

	BiH			North Macedonia			Serbia			Kosovo		
	F	M	Total	F	M	Total	F	M	Total	F	M	Total
SRHR	8	1	9	17	7	24	10	2	12	NA	NA	NA
YOUTH	2	1	3	2	6	8	5	0	5	NA	NA	NA
GE	7	1	8				5	5	10	NA	NA	NA
PD			0							NA	NA	NA
Total	**17**	**3**	**20**	**19**	**13**	**32**	**20**	**7**	**27**	**NA**	**NA**	**NA**

Client/Beneficiary Interviews and FGDs: Per the PE Design Report, it was intended for clients/beneficiaries across the four focus areas to be interviewed using a qualitative semi-structured interview questionnaire (See country/territory annexes for methodological tools). The samples presented below in Table 1.3.2.3 are convenience samples, both for topics discussed and selection of participants.

Table 1.3.2.3 ***Client/beneficiary Interviews and FGDs by country/territory and focus area***

	BiH			North Macedonia			Serbia			Kosovo		
	F	M	Total FGs	F	M	Total FGs	F	M	Total FGs	F	M	Total FGs
SRHR			0	4	1	0	15		0	19	8	5
YOUTH	3	4	1	5	3	1	5		0	19	15	5
GE			0		4	0	4		0			0
PD	6	1	1	2	3	0			0			0
Total	**9**	**5**	**2**	**8**	**8**	**1**	**24**	**0**	**0**	**38**	**23**	**10**

1.3.3. Limitations and risks

Limitations and possible biases of the approach: There are several important limitations in the proposed methods. First, due to limited time and resources it was not feasible to collect representative samples. While there was some opportunity for a randomisation process, for example for the training follow-up assessments, all other samples were largely purposive and not truly representative of the target populations of stakeholders and client/beneficiaries. The evaluation is largely qualitative in nature due to the small, non-random sample sizes. There are possible biases in the selection of respondents due to the requirement to select locations on a purposive non-random basis. In all four countries, there were instances where categories of beneficiaries were not interviewed or they were in insufficient number. This was due to limitations in staff, in the case of BiH, where it was not feasible to hire a second evaluation expert with expertise in SRH issues. In Kosovo, while a large set of interviews were conducted by a full field team, some categories of interviews, such as training follow-up interviews, were not covered. In Serbia, despite repeated efforts, it was not possible for the evaluation team to conduct the planned number of interviews. In North Macedonia, despite multiple attempts to set up FGDs with pertinent groups, only one was completed with youth. Nonetheless, all four countries managed to complete a reasonable number of key stakeholder interviews, ranging from 47 in Serbia to 76 in North Macedonia (see Table 1.3.2.1, above).

Approaches to reduce bias: As noted in the Evaluation Handbook, in order to ensure the reliability of the data collected, important issues related to bias and reliability had to be addressed. Reliability

refers to producing the same result with repeated measurements.[23] A major concern is that during interviews threats to reliability may be introduced. For example, interviewees may have underlying pre-existing opinions and perceptions based on privately held beliefs or may hold prevailing false or incomplete information on the topics discussed. In addition, the evaluators may have inadvertently introduced bias into interviews by asking leading questions, or recording data selectively based on their personally held preconceptions.

To avoid the possibility of bias from the presence of UNFPA staff, all interviews were conducted by the evaluator in private, without any UNFPA staff present. Interviews with UNFPA staff were conducted individually. To address the issue of a lack of representative samples, the interview data was supplemented with secondary data, such the CO Annual Reports (COARs), Annual Work Plans (AWPs) and other pertinent programme data, including national research studies and assessment documents, where they existed.[24] Through a process of triangulation, where multiple sources of data were assessed, it was possible to enhance the certainty that the data and information collected are valid. The results from different data collection methods (such as review of documents, interviews, group discussions and FGDs) were assessed for consistency to ensure validity of findings.

To help ensure reliability of the data collected, interviewees were selected to represent a diverse range of institutional viewpoints on key topics under review. For example, for respondents responding to questions on relevance, evaluators posed questions to a diverse range of stakeholders, not just from one institution.

CHAPTER 2: Context for the four countries/territory

2.1. Development challenges and national strategies

The following is a brief summary of some of the key development challenges and national strategies in the four countries/territory. Please see individual country/territory reports annexes for more detail.

Bosnia and Herzegovina (BiH): In line with the Dayton Peace Agreement and the Constitution created thereby, BiH is a state consisting of two entities (the Federation of Bosnia and Herzegovina (FBiH) and Republika Srpska (RS), and the Brcko District (BD) of Bosnia and Herzegovina). The FBiH further consists of 10 cantons. BiH is an ethnically mixed country, with Serbs constituting the majority in RS, and Bosniaks and Croats being the majorities in different parts of FBiH, while BD is ethnically mixed. According to the Fragile States Index 2017, Bosnia and Herzegovina features as a fragile state, in the lowest category of "elevated warning", and ranked 95th among 178 countries.

BiH has been a potential candidate for European Union (EU) membership since 2008, when the Stabilization and Association Agreement between the European Commission (EC) and BiH was signed. This Agreement entered into force seven years later, in 2015, and in 2016, BiH formally applied for EU membership. The European Commission (EC) issued its opinion on BiH's candidacy in May 2019, stating among other things that "Administrative capacity is weak and lacks effective coordination structures to manage the country's 14 governments. As a consequence, Bosnia and Herzegovina faces significant challenges in implementing and enforcing legislation stemming from its EU integration objectives. Considerable and sustained efforts are needed for the country to be able to assume the obligations of EU membership." [25]

[23] *Handbook: How to Design and Conduct a Country Programme Evaluation at UNFPA* (UNFPA Independent Evaluation Office, 2013, pp. 66-67)

[24] In BiH, there is a lack of representative statistical data that can be used to support recommendations by the evaluators. The last MICS was in 2011, so it is not possible to follow up on any trends or contributions of the UNFPA programme. Unfortunately, negotiations for a follow-up set of MICS surveys in BiH were recently discontinued by UNICEF.

[25] Please see https://ec.europa.eu/neighbourhood-enlargement/sites/near/files/20190529-bosnia-and-herzegovina-opinion_en.pdf

Bosnia and Herzegovina is an upper-middle income country. The country has a legacy of Yugoslav-era policies, simultaneously undergoing the late stages of transition from a planned to a decentralised economy, changes imposed by globalisation, and adaptations related to planned accession to the EU. Following a stable pre-global crisis expansion at about 5% annually, BiH's economy suffered instability between 2008 and 2012, with low and negative growth rates. The recovery has been slow; annual growth rates have been positive since but lower than in the pre-crisis years.

Reproductive Health in BiH : In 2015, total health expenditure in BiH was 1,365,045,168 Euros or 9.4% of the GDP, with 70.9% of this amount spent on the public health sector and 29.1% on the private health sector. An estimated 1.6% of the total health expenditure in BiH was spent on prevention of diseases and conditions and health promotion, 2.3% in RS, 1.2% in FBiH and 0.9% in the Brcko District.[26] The FBiH Government adopted the Strategy for Improvement of Sexual and Reproductive Health and Rights in 2010 for the period 2010-2019.[27] In RS, the Policy for Improvement of Sexual and Reproductive Health in RS was adopted for the period 2012-2017, [28] and a new policy document for the next ten-year period is currently awaiting adoption. The existing strategic policy documents focus on maternal health and protection, family planning and reduction of abortions, prevention of sexually transmitted diseases and infections (STDs/STIs) and malignant diseases of the reproductive organs, as well as sexuality education and awareness.

Data on sexual and reproductive health in BiH is limited. Public health institutes are tasked with collecting data and producing statistical reports, but the data is not considered fully reliable as a result of a combination of factors, not least the issues with detection and reporting of diseases and interventions, and consistency of reporting by individual data sources. The last MICS[29] was conducted for the period 2011-2012. The existing system of monitoring of sexual and reproductive health, which has specific limitations mentioned above, and which is not systemically complemented with alternative data sources, does not yield conclusive findings on the state of sexual and reproductive health.

North Macedonia: North Macedonia was one of the six republics of the SFR of Yugoslavia which gained its independence peacefully in 1991. It is an upper-middle-income country, with around 2 million population (data from Census of 2002) that has gone through major social and political changes since gaining independence. The total area of the country is 23,713 square kilometers. It is organized in eight statistical regions which exist solely for legal and statistical purposes: Eastern, Northeastern, Pelagonia, Polog, Skopje, Southeastern, Southwestern and Vardar region. Additionally, it is divided into 80 municipalities with equal status, and the capital, the City of Skopje, regulated with a separate law. The ethnic composition consists of: Macedonian 64.2%, Albanian 25.2%, Turkish 3.9%, Romani 2.7%, Serb 1.8%, other 2.2%. Minority languages are co-official with Macedonian in municipalities where they are spoken by at least 20% of the population. The Median age is 37.9 years, more precisely 30,6% are 0-24 years old, 56% are 25-64 years old and 13% are 65 years and over. According to gender, there is a balance between male (49.8%) and female (50.2%). (2002 est.[30]).[31]

During the period 2014–17, the country experienced an extended and serious political crisis. A political dialogue among main political parties, facilitated by the international community, resulted in to the "Przhino Agreement" which set the date for the new parliamentary

[26] *Chapter 28: Consumer and Health Protection* (Directorate for European Integration, 2018)

[27] *Strategija za unapređenje seksualnog i reproduktivnog zdravlja i prava u Federaciji Bosne i Hercegovine 2010-2019 godina* (Federalno ministarstvo zdravstva, 2010)

[28] *Politika za unapređenje seksualnog i reproduktivnog zdravlja u Republici Srpskoj (2012.-2017. godine)* (Ministry of Health and Social Welfare of the Republic of Srpska, 2012)

[29] *Bosnia and Herzegovina Multiple Indicator Cluster Survey (MICS) 2011-2012* (Agency for Statistics of Bosnia and Herzegovina; Federal Ministry of Health; Ministry of Health and Social Welfare of Republika Srpska; Institute of Public Health FB&H; UNICEF, 2013)

[30] It is an estimated number because is based to the last conducted census in 2002. All the data in this paragraph refers to data from the census.

[31] Republic of North Macedonia Health system review Health Systems in Transition Vol. 19 No. 3 2017

elections. The elections were held in December 2016, resulting in the formation of a new Government in June 2017. The ambitious reform agenda outlined in the Government Programme 2017–2020 focuses on economic growth, job creation, fair taxation, support to small and medium enterprises (SMEs), and reform of social protection for the most vulnerable.

An analysis of material deprivation, poverty and social inclusion identified that 30.8% of all surveyed households are materially deprived, as they cannot provide at least four of nine basic items. Only 22% of all households report being able to provide all nine items[32]. Current gross domestic product (GDP) is US$ billion 11.3. While the gross domestic product per capita in 2013 was US$ 4.800 current GDP per capita is US$ 5.200. The gross national income (GNI) per capita increased by about 31.3 percent between 1990 and 2017. The human development index (HDI) for 2013 ranked North Macedonia 84th out of 187 countries, and the gender gap index ranked it 70th out of 142 countries. The HDI value for 2017 reached 0.757, which puts the country in the higher human development category - positioning it at 80 out of 189 countries and territories.

Reproductive Health in North Macedonia: The law on health protection provides universal coverage. Public health expenditure is 4.58 per cent of total gross domestic product. Work on sexual and reproductive health is governed by the National Strategy on Sexual and Reproductive health, 2010-2020, and the National Strategy on Safe Motherhood, 2010-2015. The health information system needs improvement; currently it results in poor evidence-based planning and monitoring of financing and standards of care. The health system response to the floods in February 2015 was generally adequate; support is needed to integrate reproductive health into the emergency response.

The maternal mortality rate has decreased, from 11 per 100,000 live births in 1991 to 4 per 100,000 live births in 2012, and rose to 12,7 per 100,000 live births in 2014[33], but reliability of data remains a concern. The infant mortality rate has increased, from 7.6 per 1,000 live births in 2010 to 10.2 in 2013 and reduced to 9.2 in 2017, with 59 per cent neonatal deaths. Accessibility and quality of emergency obstetrics and neonatal care is limited by a poor referral system and insufficient capacity of health-care providers. Although antenatal care is free of charge, regulations are unclear; some women are charged for services.

The burden of diseases has shifted to non-communicable diseases, with long-term implications for productivity and health system costs. The combination of an ageing population and lifestyle changes contributed to this change and the most frequent causes of death are now circulatory diseases. The total fertility rate is currently below the replacement level (1.5), which means the population is projected to decline and age in coming years. By 2050, the population is projected to be only 1.8 million, and 35 percent of it will be over 60. In addition, elevated smoking rates, worsening dietary habits, and hypertension constitute the major risk factors in the country, which has one of the highest per capita rates of cigarette consumption in the world, with nearly 25 cigarettes smoked per day on average[34]. These demographic trends have significant implications for the provision of health care, and the sustainability of health financing.

As per the status of the maternal and infant health, certain maternal socio-demographic characteristics have a significant influence on the infant mortality rates, including education, place of residence, age, ethnicity, and marital status. The most important factor is education; among those with low and high levels of education, the mortality rates were 16.4 and 5.9 per 1,000 live newborns, respectively. According to ethnicity, the lowest infant mortality in 2013 was among the Turks (8.1%) and highest among the Roma (17.4%).

[32] Republic of North Macedonia Health system review Health Systems in Transition Vol. 19 No. 3 2017

[33] Information on mothers and child health in R.N. Macedonia in 2017, Institute of MCH, Health Home, Skopje, 2018

[34] World Bank, 2013. Getting Better: Improving Health System Outcomes in Europe and Central Asia. Washington, D.C.

Serbia: Serbia is located in South-East Europe, in the Western Balkan region. It is one of the republics that formed former Yugoslavia, which disintegrated in 1990s, and today is an independent country. Serbia was granted status of the EU candidate country in 2012, and current reforms and all national policies are marked with the efforts to fulfill conditions for EU accession. Territory of Serbia is divided into regions which do not have any administrative power, but are functional territorial units for the purposes of regional planning and policy implementation. Within these regions Serbia is further divided into districts including the City of Belgrade as one district, and within districts into municipalities and cities which are the administrative units of local self-government. According to official estimation there were 7,020,858 inhabitants in 2018[35]. Serbia has been facing unfavorable demographic trends: a low fertility rate, a negative natural growth rate, a slow increase in life expectancy, ageing (average age is 43.0) and an increase in the share of population aged 65 years and over, but also a high level of internal migration from rural to urban areas and emigration, resulting in an overall negative migration balance.

The socioeconomic context is shaped by past legacies, being a post-socialist country whose transformation toward market-oriented economy was delayed till the 2000s, when intensive structural reforms took place, along with accelerated privatization and foreign investments. These trends brought a relative improvement in the economic growth in the society. However, a few years later, it was negatively affected by the global recession crisis in 2008, where GDP was negative or only slightly positive in value. However, in recent years Serbia has succeeded in achieving a positive economic growth of GDP, as shown in percentages of annual GDP (0.76% in 2015, 2.80% in 2016, and 1.87% in 2017), according to the World Bank national accounts data, and the Organization for Economic Co-operation and Development (OECD) National Accounts data files[36]. According to the World Bank classification, Serbia belongs to the group of middle-income countries.

Reproductive Health in Serbia: The main challenges in sexual and reproductive health in Serbia are low use of modern contraception, underreported, but still high number of induced abortions, insufficient knowledge of youth about sexual and reproductive health (SRH) and related risks, and a higher incidence and mortality from preventable cervical and breast cancers compared to the EU. Gender inequalities are still underlined and there are persistent deep-rooted stereotypes and traditional roles of women and men in the family and society. Since 2015, the country has experienced a strong inflow of migrants, refugees and asylum-seekers taking the Balkan route to Western Europe. Where the maternal mortality rate is concerned, according to the data from WHO/Europe: European HFA Database (updated July 2016), the maternal mortality rate per 100,000 live births in Serbia was 12.04 (in 2014), whereas in EU it was 4.72, with a constant decreasing trend[37]. This UN target for the maternal mortality rate has been already met at the national level, and focus should be on maintaining this level and further reduction, along with the strengthening of prenatal care. The proportion of pregnancies that are ended by Caesarean section is increasing, reaching 34% in 2015.[38] The proportion of births attended by skilled health personnel is 98.4.[39]

Kosovo: Kosovo remains one of the poorest territories in Europe with very high unemployment and poverty rates compared to other countries/territories in the region, both of which have improved

[35]According to Statistical Yearbook 2018, population of Serbia is estimated to 7,020,858. Available at: http://publikacije.stat.gov.rs/G2018/Pdf/G20182051.pdf, see table 1.3.1

[36]World Bank data. Available at: https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?end=2017&locations=RS&start=1996&view=chart (Oct. 24, 2018)

[37] European health for all database (WHO-DB) WHO/Europe July 2016. Available at: http://data.euro.who.int/hfadb/ (Accessed October 25, 2018)

[38] Report on the Quality Improvement in Healthcare Institutions in Republic of Serbia. Belgrade, 2016: Republic Institute of public health "Dr Milan Jovanovic Batut", p. 152. Available at: http://www.batut.org.rs/download/publikacije/Izvestaj%20kvalitet%20rada%202017.pdf (Accessed October 25, 2018)

[39]Ibid.

during recent years. Based on the latest report produced by the Kosovo Agency of Statistics (KAS) on Consumption Poverty in 2015, the percentage of population in Kosovo living below the poverty line[40] (i.e. unable to meet human needs) decreased to 17.6 percent in 2015 from 30 percent in 2011. Similarly, the percentage of population in Kosovo living below the extreme poverty line[41] (i.e. unable to meet even basic survival needs) decreased to 5.2 percent in 2015 from 10 percent in 2011.

Similar to poverty, the labour market outcomes also improved during these years. Nevertheless, the improvements were much higher in the labour force participation rate[42] and the employment rate[43] rather than in the unemployment rate[44]. The labour force participation rate (and the employment rate) increased from 37.6 percent (25.2 percent) in 2015 to 42.8 percent (29.8 percent) in 2017. Likewise, significant progress was achieved in reducing the share of youth outside employment, education and training (from 31.3 percent to 27.4 percent) during these years. Nonetheless, very limited progress was achieved in decreasing unemployment rates. In 2017 approximately, 30 percent of the labour force was estimated to be unemployed down from 32.9 percent in 2015. The same is true for youth unemployment. Despite these improvements, the rate of labour force participation and employment rates are low by international standards, while the unemployment rate is high. The unemployment rate in the last three years has been within the range of 30-33 percent and is two times higher than the average rate in the region, and four times more than the EU average.

Economic growth is the most powerful instrument for reducing poverty and improving standards of living. During 2015-2017 in Kosovo, on average, the GDP grew by approximately 4 percent per year. Growth was largely driven by private consumption and investments (driven also by private sector investments which grew from 17.9 percent of GDP in 2015 to 19.7 percent of GDP in 2017)[45] while the government's consumption had a negative impact on the overall economic growth.

Reproductive Health in Kosovo: With regard to the overall health conditions, Kosovo shows much poorer results compared to any other country/territory in the region, though there are sustained improvements in selected indictors of maternal and child health. Life expectancy at birth[46] is about 71.6 years in Kosovo,[47] 9 years lower than Albania, 5 years lower then Macedonia and Serbia and 11 years lower than the EU average.[48] The perinatal mortality rate[49] was 12.1‰ in 2015 according to the Perinatal Situation report produced by the Ministry of Health and it is lower compared to the 2011 figure which was calculated at 17.3‰. However, this figure is still high compared to European countries, where the perinatal mortality rate is lower than 7‰.[50] There are no official reported cases of maternal deaths since 2013, although the reporting of maternal mortality is not so reliable (does not capture the inputs from the private hospitals while the media continues to report individual cases of maternal deaths). While the maternal mortality ratio per 100,000 live births was 10.5 in Kosovo in 2012 according to the Perinatal Situation report, the same rate from the regional countries, for example in Macedonia it was 7, and this ratio in the main European countries was 4[51] during the same

[40] Living below the poverty line of Euro 1.82 per adult equivalent per day.
[41] Living below the extreme (food) poverty line of Euro 1.30 per day.
[42] Ratio of employment and unemployment to working age of population.
[43] Employment to working age population ratio.
[44] Unemployed to labour force (employed and unemployed people) ratio.
[45] While overall gross fixed capital formation increased to 27.3% in 2017 from 25.8% in 2015 (IMF, Country Report for Kosovo No. 1830).
[46] Indicates the number of years a new-born baby would live if health conditions prevailing at the time of its birth were to stay the same throughout its life.
[47] https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=XK
[48] UNDP, Kosovo Human Development Report, 2012.
[49] Perinatal mortality is defined by WHO as weight specific (≥ 1000 g) fetal deaths and early neonatal deaths per 1000 births (live births + stillbirths)
[50] WHO Statistics for Europe, http://www.euro.who.int/en/health-topics/Life-stages/maternal-and-newborn-health/data-and-statistics
[51] Ministry of Health, Health Statistics for Women and Children, 2012.

year. According to the Kosovo Agency of Statistics in 2016, the infant mortality was 8.5 per 1,000 live births, whereas according to MICS mortality of infants is 12 per 1,000 live births. This is almost three times higher compared with EU countries**,** where the average infant mortality rate was 3.6 per 1,000 live births in 2015.[52]

Key Health Expenditure Indicators for the four evaluated countries/territory: As shown in the summary table below, overall health expenditures for the four countries as a percent of GDP range from a low of less than 3% to above 9%. Kosovo has failed to obtain additional financial support for health care sector in the past decade, and as a result health expenditures are a low proportion of GDP (only 2.32% of GDP in 2016). This means that Kosovo is spending a far lower share of GDP on health than any other country in the region (see Table 2.1.1 below). North Macedonia is somewhat higher at 6.09%. BiH and Serbia are nearly at par with the EU in terms of health expenditure as a share of GDP, at 9.38% and 9.41% respectively.

Table 2.1.1 Health expenditure as share of GDP by country/territory of the region (WB, Health Expenditure, 2018); Kosovo - Health expenditure as share of GDP (WB, 2015).

Country	
Bosnia and Herzegovina	9.38
North Macedonia	6.09
Serbia	9.41
Kosovo	2.32 (WHO, 2015)
European Union (N=28 countries)*	9.6

*Health at a Glance: Europe 2018: State of Health in the EU Cycle. Health expenditure as a share of GDP, 2017 (or nearest year). DOI:https://doi.org/10.1787/health_glance_eur-2018-graph78-en

Key Sexual and Reproductive Health Indicators for the four evaluated countries/territory: Trends in sexual and reproductive health, in particular for use of contraception and rates of abortion are presented in the Table 2.1.2 below. In all four countries/territory, the use of modern methods of contraception is quite low, while reliance on traditional contraception methods, especially withdrawal, is quite high. Due in part to the low efficacy rate of the modern contraception method use, rates of abortion are quite high. There is a critically important need to address these issues in the next Programme cycle.

[52] https://www.ined.fr/en/everything_about_population/data/europe-developed-countries/birth-death-infant-mortality/

Table 2.1.2: *Current Method of contraception reported by women of reproductive age as estimated by MICS4 in BiH and MICS5 Surveys in three other countries/territory; Abortion rates from three MICS surveys and BiH public health data.*

	2012		2011		2014		2013-14	
	BiH		North Macedonia		Serbia		Kosovo	
	Total	Roma et al.	Total	Roma	Total	Roma	Total	Roma et al.
Not using any method	54.2	75.2	59.8	63.0	41.6	38.8	34.2	48.2
Female sterilization	0.2	0.8	0.7	1.5	0.4	1.8	0.6	3.9
Male sterilisation	0	0	0	0.2	0	0	0.1	0
IUD	3.8	1.0	2.0	1.1	2.2	1.2	4.6	2.5
Injectables	0	0	0.2	0	0	0	0.2	0.9
Implants	0	0	0	0	0	0	0	0
Pill	1.6	2.2	1.6	0.9	3.3	1.2	2.7	3.2
Male condom	6.2	4.1	8.3	3.4	12.4	2.8	5.3	8.5
Female condom	0.2	0	0	0	0.1	0	0	0
Diaphragm/ Foam/Jelly	0	0	0	0	0	0	0	0
Periodic abstinence	3.7	0.2	2.1	0.7	4.9	2.3	0.2	0.4
Withdrawal	29.8	16.3	25.3	29.2	35	51.6	51.3	32.3
Other method	0.3	0.2	0.1	0.1	0.1	0.2	0.7	0.1
Total	100	100.0	100.1	100.1	100.0	99.9	99.9	100.00
Number interviewed	2,764	981	2537	799	2846	1533	3271	973
Number of abortions per 1,000 live births MICS5	118.7*	NA***	153.8	300.0	250.0**	434.8**	58.8	115.4

*Institute of Public Health FBIH 2018**Institute of Public Health, Republic of Srpska 2017
***Rates for Roma in BiH in 2018 not available, probably much higher than rates for FBIH and RS

Key GBV Indicators for the four evaluated countries/territory: Shown below in Table 2.1.3, are some trends in GBV related indicators for the four countries. Based on a recent survey in the four countries in 2018, there are measures of current partner violence which indicate a substantially higher prevalence of violence among women in Serbia, followed by Kosovo, with lower rates found in BiH and North Macedonia. While overall rates among current partners for the 28 EU countries combined are about the same as those in the four countries, the average rates tend to be higher for EU average for other categories, such as Previous partner, Any partner, and Non-partner. When the sustainable goal indicators for GBV are considered, the range for SDG Indicator 5.2.1: Proportion of women and girls aged 18–74 who have ever had a partner and who were subjected to physical, sexual or psychological violence by a current or former intimate partner in the 12 months prior to the survey, reveals a much higher prevalence of reported victimization, ranging from a low of 9% for Serbia to a high of 20% for Kosovo. For the SDG Indicator 5.2.2: Proportion of women and girls aged 15 or older subjected to sexual violence by individuals other than an intimate partner in the 12 months prior to the survey, the rates are far lower, ranging from a low of 0.1% for North Macedonia and a high of 0.5% for Serbia.

Table 2.1.3: Prevalence of physical and/or sexual violence since the age of 15, by type of perpetrator*												
	Current partner, %			Previous partner, %			Any partner, %			Non-partner, %		
Country	**Physical violence**	**Sexual violence**	**Physical and/or sexual violence**	**Physical violence**	**Sexual violence**	**Physical and/or sexual violence**	**Physical violence**	**Sexual violence**	**Physical and/or sexual violence**	**Physical violence**	**Sexual violence**	**Physical and/or sexual violence**
Bosnia and Herzegovina	6	2	6	11	4	11	10	4	11	7	1	8
North Macedonia	6	2	7	10	4	12	9	3	10	6	2	7
Serbia	9	3	10	17	5	18	17	5	17	8	2	9
Kosovo	8	4	9	15	6	18	9	4	11	7	1	8
EU average	7	2	8	24	9	26	20	7	22	20	6	22

*SOURCE: Organization for Security and Co-operation in Europe (OSCE)-led survey on violence against women (2018)/ European Union Agency for Fundamental Rights violence against women survey (2012) Including data collected in Kosovo. Well-being and Safety of Women: OSCE-led survey on violence against women: Main report www.osce.org ISBN: 978-3-903128-18-7

Sustainable Goal Indicators Table 2.1.3.a: SDG Indicator 5.2.1: Proportion of women and girls aged 18–74 who have ever had a partner and who were subjected to physical, sexual or psychological violence by a current or former intimate partner in the 12 months prior to the survey, by age, area and education.

	BiH	North Macedonia	Serbia	Kosovo
All women 18–74 years old	10% *(1,117)*	13% *(1,778)*	9% *(1,973)*	20% *(1,714)*

Source: Annex 6: Sustainable Development Goal Indicators in Well-being and Safety of Women: OSCE-led survey on violence against women: Main report www.osce.org

Sustainable Goal Indicators Table 2.1.3.b: SDG Indicator 5.2.2: Proportion of women and girls aged 15 or older subjected to sexual violence by individuals other than an intimate partner in the 12 months prior to the survey, by age, area and education.

	BiH	North Macedonia	Serbia	Kosovo
All women 18–74 years old	0.4% *(2,321)*	0.1% *(1,910)*	0.5% *(2,023)*	0.2% *(1,990)*

Source: Annex 6: Sustainable Development Goal Indicators in Well-being and Safety of Women: OSCE-led survey on violence against women: Main report www.osce.org

2.2. The role of external assistance

The role of external assistance to the four programmes varies considerably but has some common characteristics over time. As shown below in Table 2.2.1, the overall disbursements for the four areas have declined since 2008 and 2009 when they were at their highest levels, (ranging from over $500 million for Serbia, $438 million for Kosovo , $285 million for Bosnia and Herzegovina and $134 million for North Macedonia) to a more constant lower levels in 2016, ranging from $52 million for North Macedonia to $177 million for Kosovo. Importantly, when taking into account the size of the populations, which ranges from a high of 7 million for Serbia to a low of 1.7 million for Kosovo, the annual per capita size of the disbursements varies from $86 per person for Kosovo, to $47 per person for Bosnia and Herzegovina, $29 for North Macedonia and to a low of $25 for Serbia. Kosovo's population density at 163 per square kilometre is nearly twice that for the next highest, 91 for Serbia. The trends in assistance disbursements show that Kosovo received the most funding of all four areas in the past five years, since 2012 it received over US$ 1.1 billion.

Table 2.2.2, shows total annual UNFPA contributions to the four programmes from 2008 through 2017 (This is excluding funds from other sources for UNFPA related activities). Overall, for the past ten years, UNFPA has maintained an ongoing commitment of more than one million dollars per year to the four programmes, with the exception of 2013 when it dropped to 0.97 million. As noted above, when the relative size of the populations are considered, the highest per capita commitment has been to Kosovo (for example in 2016 it was 17 cents per capita compared to 5 cents per capita for Serbia).

Table 2.2.1. Official Development Assistance Disbursements to Four Programmes 2008 2016.

Donor	DAC Countries, Total								
Aid type	ODA: Total Net								
Part	1 : Part I - Developing Countries								
Amount type	Constant Prices								
Unit	US Dollar, Millions, 2016								
Year	2008	2009	2010	2011	2012	2013	2014	2015	2016
Recipient									
Bosnia and Herzegovina	285.82	265.62	231.24	245.94	195.24	168.68	189.54	147.23	164.62
Former Yugoslav Republic of Macedonia	134.84	127.38	89.23	67.62	73.09	96.87	79.54	45.4	51.88
Kosovo	..	438.81	180.95	177.22	281.26	254.89	241.54	185.7	177.26
Serbia	506.51	269.2	299.31	225.97	149.4	129.8	136.83	146.78	175.44

Source: Dataset: Aid (ODA) disbursements to countries and regions [DAC2a] Definition: Destination of Official Development Assistance Disbursements (ODA Disbursements). Geographical breakdown by donor, recipient and for some types of aid (e.g. grant, loan, technical co-operation) on a disbursement basis (i.e. actual expenditures). The data cover flows from all bilateral and multilateral donors except for Tables DAC 1, DAC 4, DAC 5 and DAC 7b which focus on flows from DAC member countries and the EU Institutions.

Table 2.2.2. Total UNFPA contributions to four programmes from 2008 through 2017 (excludes funds from other sources for UNFPA activities).

Donor: UNFPA											
Aid type: ODA: Total Net											
Part 1: Part I - Developing Countries											
Amount type: Constant Prices											
Unit: US Dollar, Millions, 2016											
Year		2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Recipient Countries	i										
Bosnia and Herzegovina		0.43	0.41	0.53	0.42	0.37	0.37	0.59	0.52	0.42	0.4
Former Yugoslav Republic of Macedonia		0.15	0.24	0.23	0.19	0.2	0.23	0.28	0.41	0.29	0.3
Kosovo		..	0.45	..	..	..	0.24	0.23	0.25	0.3	0.29
Serbia		0.6	0.11	0.65	0.65	0.44	0.13	0.27	0.35	0.36	0.63
Total		1.18	1.21	1.41	1.26	1.01	0.97	1.37	1.53	1.37	1.62

Data extracted on 15 Oct 2018 19:15 UTC (GMT) from OECD.Stat

Source: Dataset: Aid (ODA) disbursements to countries and regions [DAC2a]

2.3. Programme status in the context of the three UNFPA transformative goals

UNFPA aims to achieve three world-changing results by 2030, the deadline for achieving the Sustainable Development Goals.[53] These 2030 targets are as follows:

1. End maternal death, (2015 Global estimate: 216 Maternal deaths per 100,000 live births; 2030 Target: UNFPA = 0; SDG = 70).
2. End unmet need for family planning, (2015 Global estimate: 11.5 % of women 15-49 with unmet need for FP; 2030 Target: UNFPA/SDG = 0) and
3. End gender-based violence and all harmful practices. (Child Marriage - 2015 Global estimate: 7.5 % married of girls age less than 15; 2030 Target: UNFPA/SDG = 0; FGM Global - 2015 Global estimate: 34.8% of girls 15-19; 2030 Target: UNFPA/SDG = 0; Gender Based Violence - 2016 Global estimate: 18.9% of women age greater than or equal to 15 in past year; 2030 Target: UNFPA/SDG=0).

As shown below in Figure 2.3.1, there are estimated rates of progress for three of the four programmes to address these targets. Kosovo does not currently have sufficient data to generate these targets. The four programmes all have ongoing activities to address these three key results.

The UNFPA programme in BiH is in the process of development of the Population Situation Analysis that will provide inputs to the next round of United Nations Sustainable Development Cooperation Framework (UNSDCF) and Country Programme Document (CPD). According to statistical data, maternal mortality rate in BiH has been zero for several years. Due to this zero maternal mortality rate it is assumed UNFPA support to activities related to maternal mortality will be discontinued. At the same time, unmet need for family planning and gender-based violence remain in focus through building capacities of relevant stakeholders for provision of institutional family planning services, development of curricula and organisation of sexuality education for pupils in primary and high schools, as well as development of Standard Operating Procedures for assisting the victims of gender-based violence.

For the UNFPA programme in North Macedonia, the three transformative goals are all being addressed. For 2019, there are efforts to continue activities for maternal health and GBV, while putting more emphasis on family planning and prevention of early marriages. 1.Maternal mortality: The maternal mortality rate has decreased, from 11 per 100,000 live births in 1991 to 4 per 100,000 live births in 2012, but reliability of data remains a concern. Accessibility and quality of emergency obstetrics and neonatal care is limited by a poor referral system and insufficient capacity of health-care providers. 2. Family

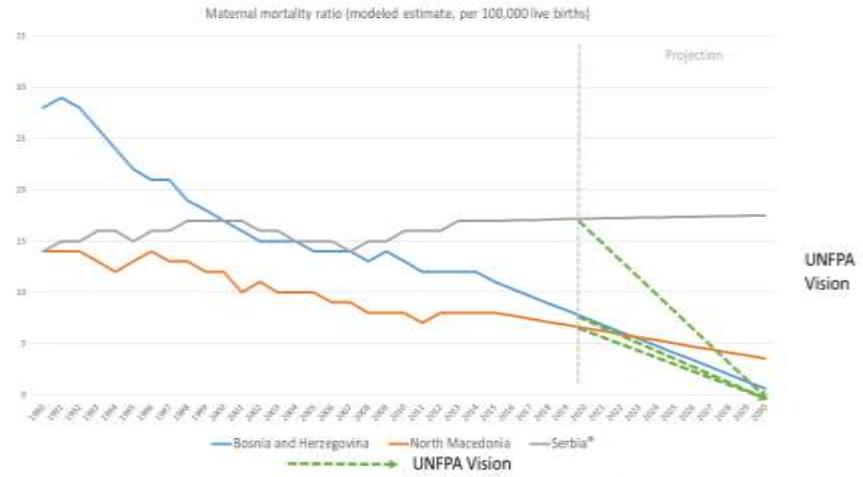
[5353] https://www.unfpa.org/data/transformative-results 25/8/2019.

Planning: The total contraceptive prevalence rate increased from 13.5 per cent among women aged 15-49 years in 2006 to 40.2 per cent in 2011. While the modern contraceptive prevalence rate has increased among women aged 15-49 years, from 9.8 per cent in 2006 to 12.8 per cent in 2011, the rates are lower among rural, poor and low-educated women, and have decreased for Roma women from 9.5 per cent in 2006 to 7.2 per cent per cent in 2011. Unmet need for family planning stands at 17.2 per cent in the total population and 22.2 per cent among the Roma. 3. GBV: While there are supportive legislative changes, widespread domestic violence and gender-based violence remain underreported, with almost half of the surveyed women experiencing at least one form of violence in their lifetime. The recently ratified Council of Europe's Convention on preventing and combating violence against women and domestic violence, known as the Istanbul Convention (2008), establishes the link between achieving gender equality and the eradication of violence against women. It recognizes the structural nature of violence against women reflected in historically and persistently unequal power relations between women and men.

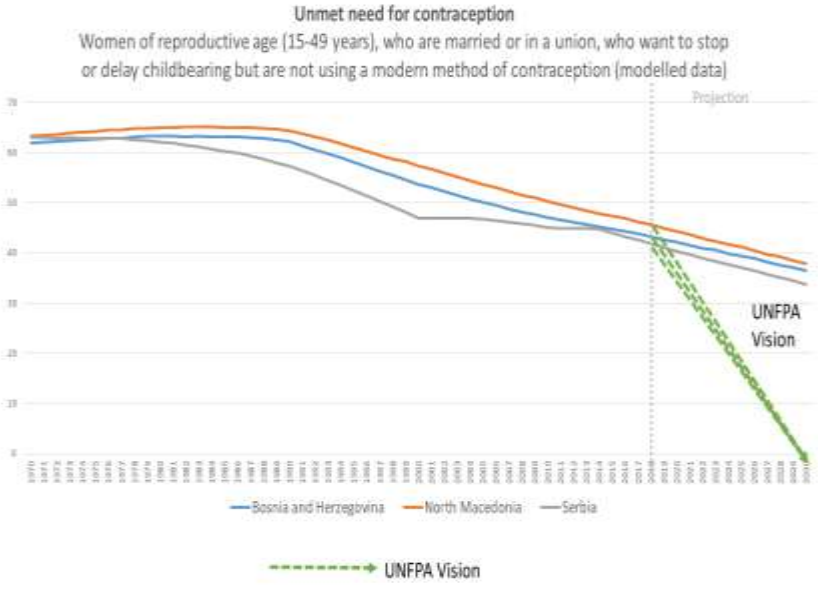
For the UNFPA programme in Serbia the three areas of effort are as follows. 1. For maternal mortality, the UNFPA in Serbia has been working on quality improvement of maternal health through "Beyond The Numbers – Reviewing maternal deaths and complications to make pregnancy safer" (BTN) initiative, which was in 2018 further expanded into an initiative to implement a National Obstetric Surveillance and Response System (OSRS) for Near-Miss Maternal Morbidities. In 2019, development of OSRS software was initiated at the cluster level, and UNFPA and the Ministry of Health initiated work on development of national guidelines for the most frequent cause of maternal deaths. Incorporation of MISP based procedure for SRH in emergency situation and MISP trainings for health professionals further contributed to quality of maternal health care in emergency situations. 2. For ending unmet need for FP, the UNFPA has been working to generate necessary evidence by conducting research in different target groups, and to increase capacity of health professionals to provide adequate advice on family planning. Capacity has been strengthened by issuing National Clinical Guidance for Modern Contraceptive Provision, and by organization of TOTs for family planning for general practitioners and gynaecologists. In 2019, the implementation of MICS 6 survey has been continued, which will provide reliable data to inform further planning. 3. For gender-based violence prevention a response was integrated into the first National programme on sexual and reproductive health. Since 2016, UNFPA has been working on capacity building of health professionals to prevent and respond to GBV, using UNFPA/VAWE resource package adopted to national context. In 2019, two trainings for health professionals were conducted in March and in May, and a Conference to sum up the previous efforts is planned for November 2019.

The current UNFPA programme in Kosovo addresses the three UNFPA Transformative goals through a series of interventions: 1. Maternal mortality: Policy development in the area of maternal health (development of the new law on SRH, sectorial health strategy and action plan on SRHRR, clinical guidelines on maternal health; Strengthening capacities of health professionals on provision of quality, timely and comprehensive maternal and new born emergency obstetrics care; and implementation of the Obstetric Surveillance and Response System); 2. Family planning: increased capacities of health professionals to provide quality and human rights based family planning services; ensuring contraceptive availability in public health sector - at the moment UNFPA is exploring possibilities to procure contraceptives for MoH through third party procurement; social marketing of male condoms; increased awareness of youth on benefits of FP, through peer education, theatre based education and social marketing; and support to the Ministry of education on implementation of comprehensive sexuality education. 3. GBV: development of policy documents on GBV; awareness raising on GBV prevention; increasing capacities of health professionals to respond to GBV survivors in terms of identification, management and referral of GBV cases; increased capacities of health professionals to provide lifesaving SRH and GBV services in case of emergencies; and advocacy activities with FBOs and young people in prevention of GBV.

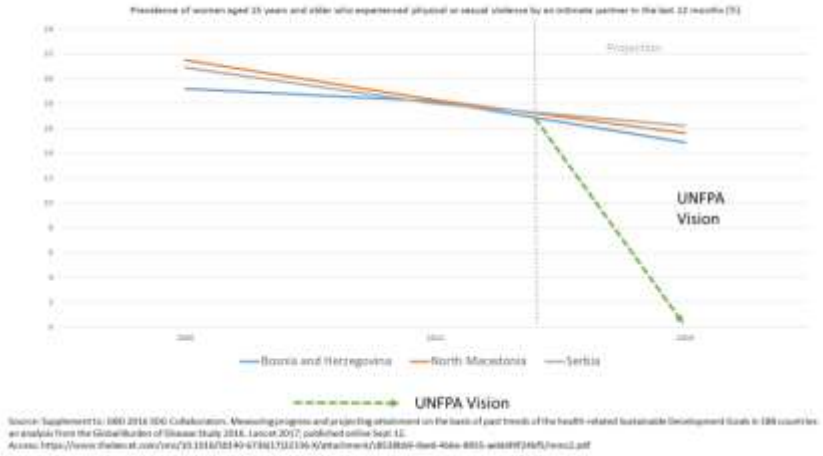
Figure 2.3.1: UNFPA Vision for Maternal Mortality, Unmet need for contraception and Gender Based Violence for BiH, Serbia and North Macedonia by 2030 (comparable data for Kosovo not available)



Source: developed based on World Bank data base (modeled estimate) https://data.worldbank.org/indicator/SH.STA.MMRT?locations=AZ
Projection was modeled using linear regression: Bosnia and Herzegovina (SE=1.89), North Macedonia (SE=0.72), Serbia (SE=0.92)
* For Serbia: statistically the prediction is not consistent (multiple R=0.27), the trend is not statistically observed, should be analyzed with carefulness.



Source: developed based on modelled data https://www.un.org/en/development/desa/population/theme/family-planning/cp_model.asp



2.4. Programme status in the context of relevant SDGs and targets

All four UNFPA offices are in the process of developing updated strategies to address relevant SDGs and targets.

The UNFPA Bosnia and Herzegovina programme is cooperating with other UN agencies in the UNCT on development of an SDG Framework that will serve as a guidance for alignment of next UNSDCF and CPD with Agenda 2030, as well as for close cooperation with relevant stakeholders on achieving Sustainable Goals. The Framework is in its draft phase and should be finalized in the next few months. The current focus of the Framework is on economic development and ensuring the rule of law in the country in line with the accession to EU processes. The focus will be on strengthening human capital in the country in order to overcome the obstacles of population changes and provide offsets for advanced emigration of the young, working age population. The most recent UNFPA Strategic Plan, for 2018-2021, has incorporated the Sustainable Development Goals (SDGs) into its framework. By adopting the Sustainable Development Goal indicators in the UNFPA integrated results and resources framework, the outcomes of the UNFPA strategic plan for 2018-2021 reflect the results shared with other partner organizations. The 2030 Agenda for the SDGs allows UNFPA to continue to implement the Programme of Action of the International Conference on Population and Development (ICPD). The UNFPA Strategic Plan is aligned with specific SDGs, most notably, to Goal 3 (Ensure healthy lives and promote well-being for all at all ages); Goal 5 (Achieve gender equality and empower all women and girls); Goal 10 (Reduce inequality within and among countries); and Goal 17 (Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development). As noted in the BiH Programme Evaluation document, the promotion of the SDGs and ICPD in BiH is relatively small proportion of the total SRH budget. For 2018, USD 15,691 was expended (8.9%) out of a total budget of USD 176,548.

UNFPA North Macedonia's efforts are geared towards SDG agenda. The National SRH Action Plan 2010-2020 was among the first national documents that considered aligning to SDGs and the targets. To be able to measure progress against SDG targets, the localization of SDG has to be completed (initiated in 2017, but recently slowed down). This is a nationwide effort, supported by the UN Family and UNFPA is part of it. UNFPA's mandate contributes primarily to SDG 3 and 5, but will be addressed to other as well, such as SGDs 1,4,8,10,16,17. In North Macedonia, there is a need for additional clarification of the UNFPA's programme activities related to the SDGs. There are SDGs which do not relate to sexual and reproductive health and rights or to gender (SDGs 3 and 5), but rather to much broader understanding of sustainable development and with much stronger focus on people, such as marginalized, vulnerable,

discriminated, at-risk, etc., than on the traditional focus areas of development. In the context of the universality and the sheer scope of coverage of 17 SDGs, with numerous targets and associated indicators, clear references to the new SP (2018-2021), the small UNFPA Country Office may encounter difficulties while trying to respond to the demanding requirements under the implementation of a vast and ambitious 2030 Agenda.

All of UNFPA Serbia's activities are aligned with the SDG agenda. UNFPA, together with other UN agencies, is contributing to the localization of the SDGs at national level. Past and current CO activities have directly contributed to SDG 3 and SDG 5, but are also addressed to other SDGs such as 1, 4, 8, 10, 16. Some of the basic indicators related to sexual and reproductive health, that are also a targets of the Sustainable Development Goals (SDGs) and the UN Development agenda 2030, are the maternal mortality rate (target 3.1), infant mortality (target 3.2) and access to sexual and reproductive health care services, including family planning (target 3.7). Where the maternal mortality rate is concerned, according to the data from WHO/Europe: European HFA Database (updated July 2016), the maternal mortality rate per 100,000 live births in Serbia was 12.04 (in 2014), whereas in EU it was 4.72, with a constant decreasing trend (page 10 of Serbia Programme Evaluation document).

The UNFPA Kosovo programme is contributing to the fulfilment of the SDGs in Kosovo, especially SDGs 3, 4 and 5. Activities currently include policy development, health system strengthening, awareness raising and strengthening capacities of health professionals. As explained in the Kosovo Programme Evaluation document, based on a Rapid Integrated Assessment conducted by UN Development Coordination Office in Kosovo, out of 13 SDG targets within SDG3, 5 are fully aligned, 5 partially aligned, 1 not aligned and 2 not relevant to the Sectoral Strategy on Health, although MoH has not explicitly referred to these SDG targets and indicators. At the time of drafting, no information was available about the status of intervention and results foreseen by the Strategy including on SDG targets and indicators that are linked to this Strategy.

CHAPTER 3: UN / UNFPA response and programme strategies for all four countries/territory

3.1. UN Strategic response

The following section summarizes the UN Strategic Response from the view point of the four programmes participating in the Cluster Evaluation.

Bosnia and Herzegovina: Two documents, which span over the period 2010 to 2020, are relevant for the evaluation period (2013-2018). The BiH Council of Ministers and the United Nations Country team (UNCT) formulated and signed the first United Nations Development Assistance Framework (UNDAF) document for the period 2010-2014 in March 2009. The second UNDAF was signed in June 2015 for the period 2015-2019. In BiH, this UNDAF was extended in 2018 through 2020. The focus areas/outcomes outlined in the two UNDAF documents have changed within the two UNDAF timeframes depending on identified priorities. The focus in UNDAF 2010-2014 was on: democratic governance, social inclusion, environment, and human security. In the 2015-2019 (2020) UNDAF, the focus on social inclusion and human security (in addition to rule of law) is maintained, and the focus areas of equitable development and employment, and empowerment of women are singled out. It is important to note that, apart from common outcomes, the first UNDAF also identifies outputs specific to individual UN agencies in BiH, while this is replaced with targets and indicators in the second UNDAF, without clearly assigned roles of individual UN agencies.[54] UNFPA has contributed to the delivery of the following focus areas/outcomes individually or in cooperation with other UN agencies in the periods 2010-2014 and 2015-2019 (2020). For 2015-2019 (2020) the Focus areas include 1. Rule of Law and Human Security. 3. Social Inclusion: Education, Social Protection, Child Protection and Health, and 4. Empowerment of women.

North Macedonia: The current **Partnership for Sustainable Development**, United Nations Strategy 2016-2020, agreed between the Government and the UN agencies on 24 October 2016, provides a strategic and legal framework for UN activities in the country for the 2016-2020 period. The UN activities during the period 2010-2015 were carried out within the framework of the previous UNDAF, which has set three broad strategic priorities for the UN agencies in North Macedonia; these are social inclusion, local governance and environmental protection.

Due to the continuity of many of the goals and activities from the previous UNDAF, they have re-appeared in the Partnership for Sustainable Development, United Nations Strategy 2016-2020. In addition, there has been another process which was reflected in the formulation of the new Partnership. Namely, while in 2014, the UNDAF 2010 – 2015 was extended to align with the National Sustainable Development Strategy 2013 – 2017, and to reflect the key MDG achievements, the new UNDAF (Partnership Strategy) 2016-2020, suggests that the legacy and achievements of the MDGs are the beginning of the work on the new 17 interconnected Sustainable Development Goals (SDGs).

Serbia: The Government of Serbia, in the close collaboration and partnership with the United Nations Country Team in Serbia (UNCT), developed a strategic document, the *United Nations Development Partnership Framework* (UNDPF) for the period 2016-2020. The UNDPF is aligned with the SDGs, the European integration priorities of EU candidate countries, and national development priorities. It consists of five priority pillars with respective outcomes. The UNDPF has been implemented by promoting the following cross-cutting programming principles: a. Promote fundamental human rights; b. Ensure gender equality; c. Promote environmental sustainability; d. Strengthen entrepreneurship and competitiveness; e. Advance independence and engagement of civil society and media; and f. Improve the quality and availability of data.

[54] When reviewing the UNDAF document, it should be taken into consideration that Joint Work Plans are annexes to UNDAF, they are developed on bi-annual basis and they have clearly assigned contributions of individual agencies to outcomes and outputs.

Kosovo: The United Nations Kosovo Team (UNKT) has prepared its second Common Development Plan (CDP) 2016-2020 as a contribution of the efforts of the international community's continuance to rally behind Kosovo to catalyse development. The CDP represents the UNKT's adoption of the global UN "Delivering as One" approach to address Kosovo's challenging development aims as one team. There are three priority areas addressed in the Common Development Plan: Good Governance and Rule of Law, Social Inclusion and Environment and Health.

3.2. UNFPA strategic response

The most recent UNFPA Strategic Plan, for 2018-2021, has incorporated the Sustainable Development Goals (SDGs) into its framework and makes a clear commitment for a joint response with three key UN agencies, UNDP, UNICEF and UNWomen. The 2018-2021 plan retains the goal of the prior UNFPA Strategic Plan for 2014-2017 and provides a strong basis for supporting the four main pillars of UNFPA activity. By adopting the Sustainable Development Goal indicators in the UNFPA integrated results and resources framework, the outcomes of the UNFPA strategic plan for 2018-2021 reflect the results shared with other partner organizations. The 2030 Agenda for Sustainable Development allows UNFPA continue to implement the Programme of Action of the International Conference on Population and Development. The UNFPA strategic plan is aligned with specific Sustainable Development Goals, most directly, to Goal 3 (Ensure healthy lives and promote well-being for all at all ages); Goal 5 (Achieve gender equality and empower all women and girls); Goal 16 (Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels); and Goal 17 (Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development).

Sixty percent of the outcome and impact indicators in the strategic plan are Sustainable Development Goal indicators. All of the Sustainable Development Goal indicators prioritized by UNFPA are captured in the integrated results and resources framework at various levels. More than half of the outcome and impact indicators are the same as those to be adopted by the three partner UN agencies mentioned above.

3.3. UNFPA response through the four programmes

The four programmes have developed tailored UNFPA national responses, which are outlined below.

Bosnia and Herzegovina: UNFPA support to Bosnia and Herzegovina began in 1995. Until 2004, UNFPA operated on a project basis. Past UNFPA assistance concentrated on improving the reproductive health status of women and adolescents and on improving access to, and the quality of, reproductive health and health education. In 2004, in accordance with United Nations reform, UNFPA participated in joint programming as part of the first UNDAF.[55] The first formal Country Programme was defined and agreed for the period 2010-2014.[56] The second UNFPA Country Programme Document for Bosnia and Herzegovina (DP/FPA/CPD/BIH/2) was approved by the UNDP/UNFPA/UNOPS Executive Board at its second regular session in September 2014. The programme initially covered the period from 2015 to 2019, but has been extended for one year through 2020.[57]

The period under review by this evaluation is 2013-2018, which spans over not only two UNFPA country programmes in BiH, but also three UNFPA strategic plans at the global level (2008-2013, 2014-2017, 2018-2021), and two UNDAF documents (2010-2014, 2015-2019/20). The country programmes have been

[55] (Executive Board of the United Nations Development Plan and of the United Nations Population Fund, 2009)
[56] (Clark, Golemec Powell, & Durmo, 2013)
[57] (United Nations Population Fund, 2018)

alligned with the UNDAF, UNFPA strategic plans, a Common Country Assessment from 2013, a pertinent CPE for BiH from 2013, as well as national priorities, including: (a) the priorities of the Bosnia and Herzegovina Coordination Board for Economic Development and European Union Integration; (b) the national development and social inclusion strategies; and (c) the country's aspiration toward joining the EU. The UNFPA country programmes were based on the basic principles of human rights and gender equality, and on the goals of the ICPD Programme of Action.[58]

In the area of *Reproductive health and rights/Sexual and reproductive health*, in line with the Country Programme Documents, UNFPA is committed to supporting the development and monitoring of evidence-based and inclusive health, health education and family planning policies; supporting access to reproductive health, reproductive health education and social protection, and supporting governments to develop regulatory and institutional frameworks to prevent and respond to HIV/AIDS and STIs. In the area of *Population and development/Population dynamics*, UNFPA has committed to strengthening evidence-based and inclusive analysis of population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality. In the area of *Gender equality*, in the Country Programme 2010-2014, the UNFPA shifted committment from support to security sector to integrate gender equality issues and mainstream gender into their policies and protocols, including those on gender-based violence. In the Country Programme 2015-2019(2020), UNFPA shifted to wider gender equality issues of advancing gender equality, women's and girls' empowerment, and reproductive rights, for the most vulnerable and marginalized women, adolescents and youth. In the area of intervention related to *Adolescents and youth*, which is an additional outcome in the Country Programme 2015-2019(2020), UNFPA has committed to contributing to national development policies and programmes to integrate the needs of adolescents, particularly young adolescent girls, and particularly in terms of increased availability of comprehensive sexuality education and sexual and reproductive health. BiH is a pink country in terms of UNFPA global categorization. This means that the allowed modes of intervention for UNFPA in BiH are advocacy and policy dialogue/advice, capacity development and knowledge management. The BiH Logic Model is shown in the BiH Evaluation Report - Annex 9.

North Macedonia: The UNFPA programmatic response in North Macedonia is presented through a sequence of activities posted in hierarchical order and with causal interlinkages between conditions and results formulated as the goal of the UNFPA at global level. This goal is defined as "achievement of universal access to sexual and reproductive health, the realization of reproductive rights, and the reduction in maternal mortality to accelerate progress on the International Conference on Population and Development (ICPD) agenda, to improve lives of adolescents and youth, and women, enabled by population dynamics, human rights, and gender equality" (UNFPA Strategic Plan 2014-2017, p.4).

Following a theory of change logic, the results chain from the above cited overarching goal leads to the sequence of *outputs* and *outcomes* of the UNFPA strategic plan (2014-2017) at the global level, followed by the most recent UNFPA strategic plan 2018-2021. The outcomes of the Strategic plan contributes to all 17 SDGs, but most directly refer and align to the SDG3, SDG5, SDG10 and SDG17. The next (top down) level of the UNFPA programmatic response is presented by the Country Program Document (CPD) and the implementation instruments, the Annual Work Plans (AWPs). The UNFPA has been working in North Macedonia since 2007, on implementation of projects focused on (a) sexual and reproductive health, including youth sexual and reproductive health; (b) gender equality and violence against women; and (c) development of evidence -based population strategies.

[58] (Executive Board of the United Nations Development Plan and of the United Nations Population Fund, 2009), (Executive Board of the United Nations Development Plan and of the United Nations Population Fund, 2014)

Currently, the UNFPA implements its third Country Program, within the 2018-2021 strategic framework set at the global level. The current five-year Country Programme Document (CPD) 2016-2020 was developed in cooperation with the Government and other development partners. This programme was approved by the Executive Board in 2015. The Country Programme applies the human rights based approach and aligns with the national priorities, EU integration requirements, the SDGs, the Programme of Action of the International Convention on Population and Development (ICPD), the UNDAF and other international and national documents reflecting the UNFPA underlying goals and principles. The guiding principles include access to affordable, high-quality integrated sexual and reproductive health services, strengthened accountability, and elimination of all forms of discrimination; and empowerment of marginalized groups, with a focus on the beneficiaries of social transfers, Roma and rural women, adolescents and youth, particularly girls, and key populations at risk of HIV infection.

In implementing its interventions, the UNFPA is guided by three underlying principles (UNFPA Country Program Document for The former Yugoslav Republic of Macedonia (2016-2020), 30 June, 2015, p.3):

(a) access to affordable, quality integrated SRH services that meet human rights standards;
(b) the need for strengthened accountability in order to eliminate all forms of discrimination;
(c) the aim of empowering the most marginal groups, with a focus on women, adolescents and youth (particularly girls), and marginal and key populations at higher risk of HIV.

Serbia: The work of UNFPA in Serbia started in 2006, guided by UNDAF framework. Since 2007, UNFPA has implemented stand-alone projects, within the United Nations Development Assistance Framework (UNDAF). The UNDAF evaluation and the evaluative evidence[59] highlighted the following for Serbia: (a) sustainable development and social inclusion are still highly relevant; (b) increased focus on the older people due to demographic ageing is needed; (c) investment in core areas of UNFPA work, including achieving positive changes in reproductive health, women's empowerment and population trends, remains relevant; (d) UNFPA should continue to support the realization of international standards by supporting civil society organizations and networks towards universal access to sexual and reproductive health, the realization of reproductive rights, family planning, ageing and empowerment of young people; and (f) UNFPA should continue its efforts in better positioning the office in relation to national counterparts and within the region. The first UNFPA five year Country Programme Document (CPD) 2016-2020 was developed in 2015, in line with UNDAF (2016-2020) and the UNFPA Strategic Plan 2014-2017. The Country Program 2016-2020 has four outcomes that cover the following areas of the UNFPA mandate: *Reproductive Health and Rights; Youth Health; Gender Equality and Empowerment of Women; Population and Development.*

The first five-year Country Programme (2016-2020) is being implemented in close partnership with the Government of Serbia. This includes collaboration with the Ministry of Health of Serbia; Ministry of Youth and Sport; Minister without portfolio responsible for demography and population policy, Ministry of Labour, Employment, Veterans and Social Affairs, and members of parliament (MPs). The financial assistance of the Country Programme (2016-2020) approved by Executive Board foresaw a total of $2.5 million out of which $1.5 million from regular resources and $1 million through co-financing modalities and/or other responses.

A simplified logic model illustrates how planned activities in four focus areas are to achieve outputs that,

[59] "Evaluative Evidence" Using Light Methodology of the UNFPA Programme Framework of Assistance to the Government of the Republic of Serbia (2011-2015), March 2015

in turn, will accomplish four major UNFPA Country Programme Outcomes in Serbia. These four major outcomes are to contribute to the above mentioned three UNDAF pillars and the overall UNFPA goal: *''To improve the lives of women, adolescents and youth, through achieved universal access to sexual and reproductive health, realized reproductive rights, reduced maternal mortality to accelerate progress on the ICPD agenda; enabled by population dynamics, human rights and gender equality''* The four focus areas, with corresponding outcomes and outputs are as follows: *Reproductive Health and Rights* Outcome 1, *Youth Health* Outcome 2, *Gender Equality and Empowerment of Women,* Outcome 3 and *Population and Development* Outcome 4.

Kosovo: Currently, UNFPA in Kosovo is implementing its first development programming document for Kosovo developed in a participatory approach with partners, and approved by Executive Board in 2015. [60] UNFPA Programme is organized around three outcomes that covers the following areas of UNFPA mandate: (i) ***Sexual and reproductive health:*** which aims to support Kosovo's efforts to deliver integrated sexual and reproductive health services with special focus on youth and vulnerable groups; (ii) ***Adolescents and youth:*** which is dedicated to improve national capacity to design and implement community and school based comprehensive sexuality education programmes that promote human rights and gender equality; and (iii) ***Population dynamics:*** which is directed to strengthen institutional capacity for the formulation and implementation of rights-based policies that integrate evidence on population dynamics, sexual and reproductive health, HIV and their links to sustainable development.

The current programme is fully aligned with national priorities, UNFPA Strategic Plan 2014–2017 and the UN Kosovo Team (UNKT), Common Development Plan (CDP) (an UNDAF-like planning document) and with Sustainable Development Goals (especially with SDGs 3 and 5). UNFPA programmatic activities directly contribute to achievement of strategic and specific objectives of the Sectoral Strategy for Health covering the period of 2017-2021. More specifically UNFPA programme is linked to (i) Specific Objective 1.2 of the Sectoral Strategy on ***mother and child health*** which aims to improve perinatal and mortality rates; (ii) specific objective 1.1. on ***Promotion of healthy lifestyle*** which aims to educate lower and upper secondary students on health and healthy lifestyles; (iii) specific objective 3.7 on ***Delivery of health services*** aiming more specifically to improve Screening Programmes for breast, cervical cancer and supply of essential medical products to health institutions including products related to SRH.

The UNKT CDP which covers the period 2016-2020, is organized around three (3) strategic themes (governance and rule of law, social inclusion and environment and health) aiming to contribute to achievement of nine (9) development outcomes. The UNFPA has been directly contributing to the three CDP outcomes, two on duty bearers and one on right holders. The first one is related to application of evidence from population data by institutions to their policy making decisions (outcome indicator 1.3.1). The second one is about improving coverage of quality and equitable essential health care services for Maternal, Neonatal, Child and Reproductive Health (MNCRH) and Non-Communicable Diseases (NCD) (outcome 3.2) whereby UNFPA programmatic activities contributes directly to improvement of quality and equitable essential health care services for MNCRH. The last one is about rights holders contributing to the change of people behaviours through adoption of more healthy behaviours including on SRH (outcome 3.3).

As shown in the Figures in the Kosovo Evaluation Report Annex 8, the logic model for Kosovo illustrates how the planned activities in the four focus areas contribute towards the achievement of outputs which

[60] Previously, due to the unresolved status situation, the UNFPA office in Kosovo was not operating within the formal Country Programme framework, but rather based on a project-by-project basis environment.

should in turn accomplish four major Outcomes. These four major outcomes contribute towards the goal of "Achieved universal access to sexual and reproductive health, realized reproductive rights, and reduced maternal mortality to accelerate progress on the ICPD agenda, to improve the lives of adolescents and youth, and women, enabled by population dynamics, human rights and gender equality". The four focus areas of outcome are Reproductive Health Outcome 1, Youth Outcome 2, Gender Equality Outcome 3, and Population and Development Outcome 4.

3.4 The programmes' financial structure

While there are important similarities among the four programmes, there are important differences in the programme financial structures. The most recent five-year UNFPA award summary budgets are shown for the four programmes below in Table 3.4.1**.** which summarizes the four five-year programme financial outlines for 2015 through 2020. Three of the four programmes began with proposed budgets of $2.5 million, while the programme for Bosnia and Herzegovina was allocated slightly more at $3.4 million. The focus of these four CPA programmes are similar, with all four programmes including significant components for SRH, Adolescents and Youth and Population Dynamics, generally providing significantly more funding for SRH and ARH compared to PD. Bosnia and Herzegovina has a fourth programme component for Gender Equality and Women's Empowerment which accounts for its higher overall budget. The initial expectation was for all programmes to obtain additional funding over and beyond the regular resources provided by UNFPA. Bosnia and Herzegovina was provided with a slightly lower expectation of obtaining external funding, at 29% (= 1/3.4) versus 40% (=1/2.5) for the other three countries. By mid-2018, UNFPA office in BiH has managed to fundraise over $ 1.2 million, mostly for the gender equality and women's empowerment component. By mid-2018, the UNFPA office in North Macedonia has managed to fundraise over $ 0.5 million, mostly for the humanitarian preparedness and response in the period 2015-2016 from internal, UNFPA and donor resources, and, SRH and GBV activities and support to Persons with Disabilities (PwD). Total external donor funding received by UNFPA Serbia from 2015 to mid-2018 was USD 513,278.67, while for Kosovo, the total external donor funding for this period was $648,117**.** As of 2018, Kosovo's category has been changed from pink to yellow, which resulted in an increase of its ceiling from $ 0.3 to $ 0.54 million.

As shown in the next set of tables, Table 3.4.2. Summary of Programme Expenditures for the Four Programmes from 2013 through to 2018, there is a clear general pattern of greater expenditure for SRH in most years for three of the four programmes. With the exception of Year 2014, Bosnia and Herzegovina stands out for a greater expenditure on Gender Equality and Women's Empowerment (GEWE) compared to SRH. It should be noted that there was significant programme funding allocated to GEWE for the years 2013 through 2018 for Kosovo and for Serbia, despite the fact that this category was not included in the initial budget formats shown above in Table 3.4.1. This was especially pronounced for Kosovo, where GEWE was the second highest expenditure for the past four years, from 2015 to 2018. Expenditures for Programme Coordination and Assistance (PCA) tended to follow a similar pattern for all four programmes. The highest expenditures for PCA, were for 2013 and 2014, often exceeding $100,000, followed by a gradual reduction to less than $50,000 per year by 2018. This is to be expected given the initial management difficulties and challenges faced at the beginning of the programmes, which required more administrative costs.

Table 3.4.1 Summary of four five-year country programme financial outlines for 2015 through 2020.

Bosnia and Herzegovina: $3.4 million: $2.4 million from regular resources and $1.0 million through co-financing **Programme period:** Five years (2015-2019) **Cycle of assistance:** Second **Category:** Pink

Strategic plan outcome area		Regular resources	Other	Total
Outcome 1	Sexual and reproductive health	0.8	0.2	1.0
Outcome 2	Adolescents and youth	0.7	0.2	0.9
Outcome 3	Gender equality and women's empowerment	0.3	0.4	0.7
Outcome 4	Population dynamics	0.3	0.2	0.5
	Programme coordination and assistance	0.3	-	0.3
	Total	**2.4**	**1.0**	**3.4**

North Macedonia: $2.5 million: $1.5 million from regular resources and $1 million through co-financing modalities and/or other resources, including regular resources. **Programme period**: Five years (2016-2020) **Cycle of assistance:** First **Category per decision 2013/31**:Pink

Strategic plan outcome areas		Regular resources	Other resources	Total
Outcome 1	Sexual and reproductive health	1.1	0.7	1.8
Outcome 2	Adolescents and youth	0.1	0.2	0.3
Outcome 4	Population dynamics	0.1	0.1	0.2
Programme coordination and assistance		0.2	–	0.2
Total		**1.5**	**1.0**	**2.5**

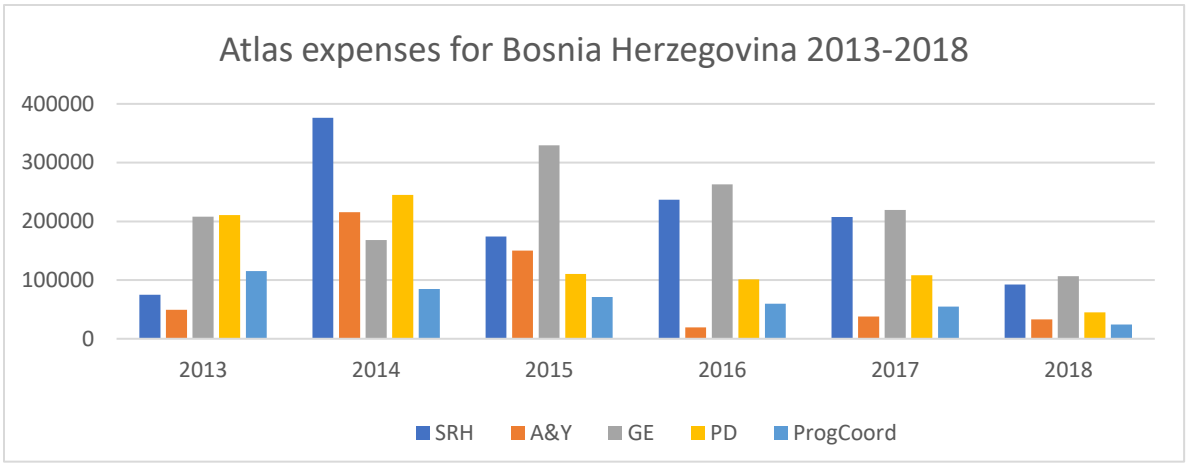
Serbia: $2.5 million: $1.5 million from regular resources and $1 million through co-financing modalities and/or other resources, including regular resources **Programme period:** Five years (2016-2020)
Cycle of assistance: First **Category per decision 2013/31:** Pink

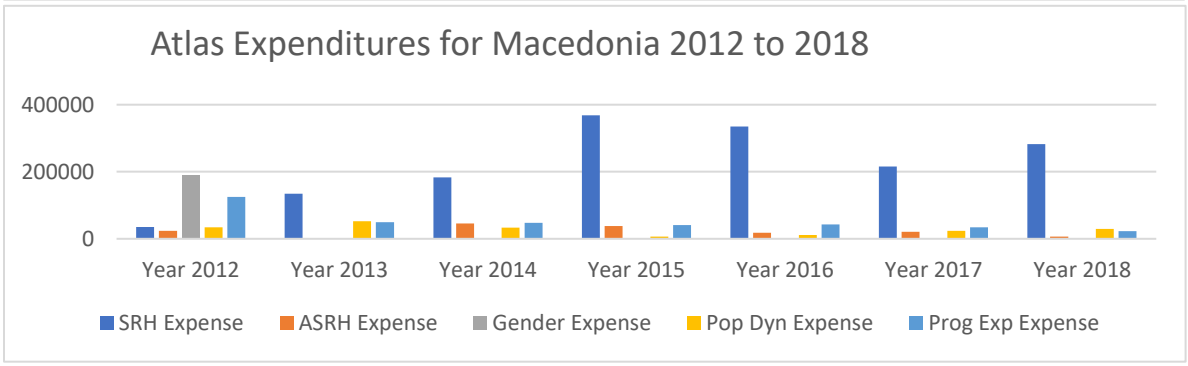
Strategic plan outcome areas		Regular resources	Other resources	Total
Outcome 1	Sexual and reproductive health	0.40	0.40	0.80
Outcome 2	Adolescents and youth	0.45	0.30	0.75
Outcome 4	Population dynamics	0.45	0.30	0.75
Programme coordination and assistance		0.20	–	0.20
Total		**1.50**	**1.00**	**2.50**

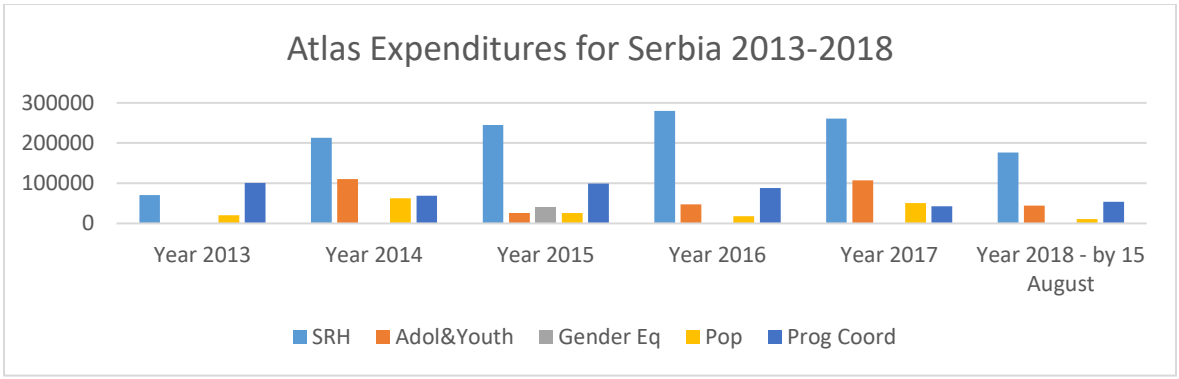
Kosovo: $2.5 million: $1.5 million from regular resources and $1million through co-financing modalities and/or other resources.
Programme period: Five years (2016-2020) **Cycle of assistance:** First. **Category:** Pink/Yellow

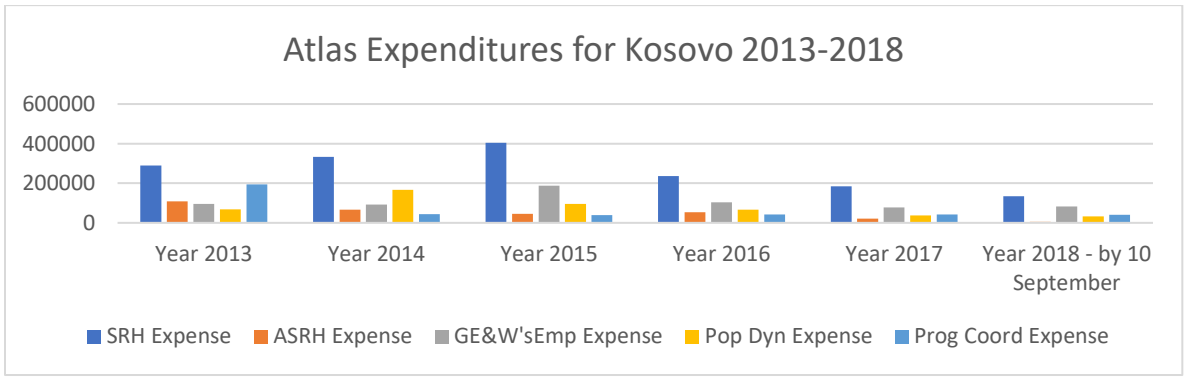
Strategic plan outcome areas		Regular resources	Other resources	Total
Outcome 1	Sexual and reproductive health	0.6	0.7	1.3
Outcome 2	Adolescents and youth	0.4	0.1	0.5
Outcome 4	Population dynamics	0.3	0.2	0.5
Programme coordination and assistance		0.2	-	0.2
Total		**1.5**	**1**	**2.5**

Table 3.4.2. Summary of programme expenses for the four programmes from 2013 through 2018









CHAPTER 4: Findings

4.1. Sexual and Reproductive Health

Section 1. Relevance

EQ1. To what extent is the UNFPA programme (i) adapted to the needs of women, adolescents and youth, people at risk of HIV infections, disabled and older persons, and Roma, (ii) and in line with the priorities set by the international and national policy frameworks, (iii) aligned with the UNFPA policies and strategies and the UNDAF as well as with interventions of other development partners? Do planned interventions adequately reflect the goals stated in the UNFPA Strategic Plan?
EQ2. To what extent has the programme office been able to respond to changes in the national development context and, in particular, to the aggravated humanitarian situation in countries/territory?

EQ1.A Assumption 1: The evolving needs of women, adolescents and youth, people at risk of HIV infections, disabled and older person and Roma, were taken into account in programme design (both CPD and Annual Planning) and implementation (e.g. targeting/selection of beneficiaries).
EQ1.B Assumption 1: The evolving priorities set by the international and national policy frameworks were taken into account in UNFPA programme design (both CPD and Annual Planning) and implementation (e.g. targeting/selection of beneficiaries)
EQ1.C Assumption 1: There is evidence of alignment between the UNFPA programme and a) UNFPA policies and strategies, b) the UNDAF (or equivalent document) and c) interventions of other development partners.
EQ1.D Assumption 1: The planned interventions adequately reflect the goals of the UNFPA Strategic Plan
EQ2.A Assumption 1: The UNFPA country office has a mechanism in place to facilitate responses to changes in the national development context.
EQ2.B Assumption 1: UNFPA has provided a timely, appropriate and sufficient response to an aggravated humanitarian situation.
EQ2.B Assumption 2: The current UNFPA CP reflects and is effectively aligned with these key policy/strategy areas: UNFPA Strategic Plan and strategies, goals of ICPD PoA, and the SDGs.
EQ2.B Assumption 3: It is assumed that the UNFPA CP has explicitly attempted to attain consistency with the four separate areas: UNFPA policies, ICPD PoA, MDGs and the SDGs. **NB: The SDGs were not adopted at the time of CPD drafting and approval.**

NB: The detailed listing of key assumption questions addressed below are also shown in Annex 2.

There is strong evidence in all four countries that the UNFPA SRH programmes have been adapted to the needs of women, adolescents and youth, people at risk of HIV infections, disabled and older persons, and Roma. But there is some reservation about the priorities paid to different groups. For example, in BiH there was evidence that the UNFPA programme has been adapted to some extent to different needs of different groups of population, most notably women, but not of marginalized and vulnerable populations. The partners in delivery of activities believe that UNFPA programme is generally well adapted to the needs of specific target groups, particularly women. However, there are also those who believe that persons with a disability, youth, people at risk of HIV infection, and Roma have been largely neglected in this area of intervention[61]. This was particularly reflected in trainings developed and delivered to family medicine doctors on Family Planning without a specific focus on implications for individual categories of population.

For Kosovo, most of the key activities (such as training of PHC staff, efforts to support contraception with the MoH establishing a budget line for contraceptives, and the support for the OIK National Assessment of the Reproductive and Sexual Health) are highly pertinent and relevant to the needs of the target populations. For North Macedonia, the choice of the target groups was felt to be appropriate and the

[61] It should be noted that this was a strategic management decision, not to single out vulnerable categories, particularly Roma outside the mainstream healthcare system due to other negative experiences in the region. Instead it was felt that the focus should be on socio-economically disadvantage groups.

needs of those groups are largely responded to. However, based on evidence gathered through desk research and stakeholder and beneficiary interviews, there was a weakness regarding insufficient or delayed response to the needs of Roma and PwDs. The evidence suggests that the needs of the target group of Roma have not been sufficiently addressed despite the fact that this target group faces a multitude of barriers in the access to sexual and reproductive health services, and suffers from a multitude of poor health outcomes.

All four programmes found that the UNFPA initiatives on SRH are largely aligned with international and national policy frameworks and have been able to adapt to a changing local context. There was also evidence that the UNFPA initiatives were aligned with the UNFPA policies and strategies and the UNDAF as well as with interventions of other development partners.

There was clear evidence in all four countries/territory that the planned interventions adequately reflect the goals of the UNFPA Strategic Plan. In all four countries/territory, there was evidence that the current UNFPA programmes reflect and are effectively aligned with the key policy/strategy areas of the UNFPA Strategic Plan and strategies, goals of ICPD PoA, the MDGs, and the SDGs. This is with the caveat that the SDGs followed the most recent country/territory plan development.

It is clear that three of the four programmes, the exception being Kosovo, were able to provide timely, appropriate and sufficient response to important humanitarian situations. For three of the four programmes, BIH, Serbia and North Macedonia, there were important national emergencies that required an urgent UNFPA response. For BiH, the biggest changes in the national development context occurred at times of specific crises, most notably during the 2014 floods and 2018 migrant crisis. In both cases, UNFPA was among the first responder agencies. In Serbia, UNFPA response to the humanitarian immigration crisis was assessed as immediate, being one of the first UN agencies to respond, without administrative barriers that would prevent them from reacting early, and targeting the needs that could have been easily overlooked. In North Macedonia, the important role of the UNFPA in humanitarian context, internationally acknowledged by its membership in the Inter-Agency Standing Committee, as a primary mechanism for inter-agency coordination of humanitarian assistance, became particularly important during the refugee crisis from January until November 2015 when Europe witnessed massive movements of around 1 million refugees. The Minimum Initial Service Package (MISP) was implemented by all four programmes. In Kosovo, while there were no emergencies, UNFPA's interventions related to MISP are highly relevant in the context of emergency preparedness which has been implemented for the first time in Kosovo.

All four countries/territory have attempted to be consistent with the four separate areas of UNFPA policies, ICPD PoA, MDGs and the SDGs. All UNFPA interventions contribute to the achievement of the Sustainable Development Goals (especially with the SDGs 3 and 5) although the SDGs and agenda 2030 were not adopted at the time of CPD approval in 2015.

Section 2. Effectiveness

Effectiveness EQ3. To what extent have the intended programme outputs been achieved? To what extent did the outputs contribute to the achievement of these planned outcomes: (i). increased utilization of integrated SRH Services by those furthest behind?

EQ3.A Assumption 1: Assumes intended and unintended program outputs have been achieved to some extent.

EQ3.B Assumption 1: Assumes all intended and unintended outcomes have been achieved to some extent.

EQ3.B Assumption 2: Assumes that the majority of progress on intended outputs can be attributed to UNFPA CP. It is unlikely that all progress towards outputs can be attributed to a given intervention.

NB: The detailed listing of key assumption questions addressed below are shown in Annex 2.

For all four countries/territory, there have been important accomplishments for SRH outputs. For example in BiH, family planning counselling as part of integrated SRH services targets was partly met (targets 1 and 3). Based on stakeholder interviews, the SRH strategy in Republika Srpska was successfully drafted in 2018 and was submitted for adoption in 2019. The planned number of clinical guidelines for maternal health has been achieved (target 2)[62]. On the issue of increased utilization of integrated SRH Services by those furthest behind, the BiH report found no available data to show whether marginalized groups have utilized integrated SRH services in BiH; there is evidence of UNFPA programme interventions creating a basis for increased utilization of integrated SRH services, but not focusing on those furthest behind.

In North Macedonia, during the initial period for the first Country Programme Document (CPD), the monitoring of the results achieved was found to be somewhat random, based mostly on qualitative assessments of the level of the achievement of the expected results. A proper monitoring results framework was constructed when the CPD for the period 2016-2020 was adopted. The achievement to date for Indicator 1 is "over-achieved", as 18 guidelines, protocols and standards had been developed by 2018.

In Serbia, based on an in-depth vertical review (in the period 2016 and 2017) of programme documents and interviews with stakeholders, it was found that the programme outputs related to the sexual and reproductive health focus area were achieved to a great extent in the first two years of the implementation of the programme for CPD 2016-2020 (Standard Progress Report for 2016 and 2017, COAR 2016 and 2017). Of five key outputs, most have been achieved.

In Kosovo, there was significant progress in MCH through the CGP development/adaptation process that was institutionalized during 2017. Under the guidance and with the support of UNFPA, trained local experts in 2016 have adapted three clinical guidelines for major causes of maternal mortality/morbidity in Kosovo (postpartum haemorrhage, eclampsia and preeclampsia, and cervical cancer screening), and a clinical guideline on Prevention of HIV Transmission from Mother to Child. During 2018, an additional eight Clinical Guidelines were developed instead of five planned. There have been mixed results for advocacy efforts with the MoH in establishing a budget line for contraceptives. The MoH is considering procurement of contraceptives through a special budget line from the essential drug list, through a UNFPA third-party procurement modality, but there as yet has been no change in MOH Policy.
For SRH related activities, while not all progress can be attributed to UNFPA, it is clear that the much of the progress on intended outputs can be attributed to the UNFPA programmes in all four countries. For example, in BiH the UNFPA has been the sole technical assistance provider among donor and development agencies in the areas of Family Planning and drafting of SRH related clinical guidelines; while the BtN methodology was created by WHO, and UNFPA was in charge of rolling it out in BiH adapted as OSRS. For this reason, the majority of progress on intended SRH related outputs can be attributed to UNFPA. In Kosovo, there is strong evidence to attribute a majority of progress on intended SRH outputs to UNFPA interventions. In Serbia, the majority of progress related to achieving SRH outputs was attributed to UNFPA activities, since none of the other agencies or institutions have a mandate to focus on supporting national institutions to increase their capacities to deliver integrated reproductive and sexual healthcare services. Similarly, in North Macedonia, much of the progress on intended outputs is attributable to the programme activities.
Achievement of Outcomes: There is evidence of progress for the achievement of intended outcomes for three of the four countries. For BiH, conclusions re outcomes were mixed. Stakeholders views on how the

[62] In fact, Serbia may have exceeded the target (Guidelines for guidelines, pre-eclampsyax2, PPHx2, and now in the process of developing ante-natal clinical guide).

Family Planning repositioning concept was adapted to marginalized groups varied. Some said that the concept was developed as one-size-fits-all, while others argued that specific attention was paid to marginalized groups such as persons with disabilities and Roma. For this reason, no clear conclusions could be drawn on the delivery of this part of integrated SRH services to marginalized groups in BiH. The lack of affordable contraception is an impediment to successful rollout of SRH services. In Kosovo, there was evidence of progress for some MHC outcomes. For example, effective perinatal care based on reports from regular EPC follow-up assessment/visits, especially in the General Hospital in Prizren but also in other maternities. For Serbia, when it comes to achieving outcome indicators related to sexual and reproductive health and reproductive rights, key informants were consistent in their response that it is too early to assess progress, especially having in mind that the First National Programme for preserving and promoting Sexual and Reproductive health of the citizens of Serbia has been just officially launched in 2018 and costing for the implementation has yet to be done. For North Macedonia, maternal health and the co-related health of the newborns have been a central part of UNFPA's support. The most prominent activity has been capacity building for evidence-based practices in effective perinatal care (EPC), co-funded by the Government and UNFPA. The equitable access to the quality reproductive health for marginalized groups, especially Roma, raises concern and requires additional UNFPA effort.

EQ 4 To what extent has UNFPA contributed to an improved emergency preparedness in BiH, The former Yugoslav Republic of Macedonia, the Republic of Serbia, and Kosovo (UNSCR 1244), and in the area of maternal health / sexual and reproductive health including MISP?
EQ5 To what extent has each office been able to respond to emergency situations in its Area of Responsibility (AoR), if one was declared? What was the quality and timeliness of the response?

EQ4.A Assumption 1: There is an emergency preparedness plan, which is complete and updated.
EQ4.B Assumption 1: UNFPA has contributed to MISP preparedness.
EQ4.B Assumption 2 : The activities and outputs have contributed to a measurable and meaningful extent to the achievement pertinent to emergency preparedness, maternal health and SRH including MISP.
EQ5.A Assumption 1: UNFPA is able to respond to emergency situations if they are declared.
EQ5.B Assumption 1: If UNFPA was asked to respond to an emergency situation, it responded with quality and in a timely fashion.
EQ5.B Assumption 2: The UNFPA CP has encountered significant constraints as well as facilitating factors that both impeded and aided the achievement of results in the GBV AoR.

NB: The detailed listing of key assumption questions addressed below are shown in Annex 2.

Emergency preparedness: There has been significant participation by all four UNFPA programmes in the development of emergency preparedness planning. Among the four UNFPA programmes, however, the role of Kosovo has been more restricted, as there have not been any comparable flood or immigration related emergencies. There is no single emergency preparedness plan for BiH, but individual entities have their own individual plans on responding to emergencies. The UNFPA in Serbia reported that minimum preparedness for humanitarian disasters has been established by the programme, which conducted emergency preparedness processes and activities to help mitigate risk of the onset of a crisis (COAR 2017). As a part of emergency preparedness and disaster risk reduction, UNFPA in Serbia achieved some key results, including delivering of a workshop for 20 policy makers and public health professionals to raise awareness on a minimum initial service package (MISP) for SRH (COAR 2015). The UNFPA in North Macedonia has contributed to improved emergency preparedness in relation to the humanitarian crisis which erupted in 2015. Follow up activities included coordination and monitoring capacity of the health system and GBV-related services, distribution and utilization of UNFPA donated RH kits and supplies.

Contribution to MISP preparedness: All four UNFPA programmes have contributed to MISP preparedness. In BiH, UNFPA supported MISP related trainings that were implemented in 2013 and 2017. There is a MISP working group coordinated by the Ministry of Civil Affairs, gathering representatives from the whole country. The UNPFA in Kosovo assisted the adoption and integration of the MISP through various activities. UNFPA initially supported the Kosovo Red Cross in organising ToTs and delivering training on MISP to PHC personnel. During 2013- 2017, around 370 healthcare providers were trained (about 78% women) on this programme. The training has been accredited and became part of Continuous Development Programme for family physicians and nurses. UNFPA Serbia significantly contributed to preparedness for MISP, as evidenced by stakeholders and confirmed by document review. In North Macedonia, a budget contribution of around $45,000 was allocated for preparedness for MISP from the UNFPA's Emergency Fund dedicated for MISP plan activities (2015). The activities were initially conducted by UNFPA, while later most of the activities were assigned to IP HERA

.

Emergency Response: UNFPA support for the 2014 floods in BiH included, among others, the rapid post floods assessment of PH facilities; Kosovo was not affected by migration flow (it is not part of the main route of migration flows), and it was not affected from floods. Emergency situations in Serbia have not been officially declared, but in 2014 Serbia faced extreme floods that caused a significant humanitarian emergency. According to the interviews, UNFPA CO was one of the first agencies who reacted and provided help and support within their mandate. According to the Standard Progress Report for 2014, UNFPA in Serbia was able to mobilize non-core resources from the UN Human Security Trust Fund, in the amount of 65,126 USD, and 114,913 USD from Central Emergency Response Fund (CERF). For that purpose, emergency RH kits were purchased and delivered, in the amount of 103,051 USD (data from ATLAS for 2014). Evaluative evidence suggests that the UNFPA in North Macedonia has succeeded in responding to an emergency situation comprehensively. The health sector clinical response provides clear evidence of UNFPA's contribution to the provision of quality accessible SRH and GBV related services. In the first half of 2016, the response included provision of fixed and mobile health facilities.

Constraints and facilitating factors for GBV: In Kosovo, regarding GBV, when PHC personnel were asked why there is no delivery or little delivery of services to GBV victims, they reported that victims are usually directed to emergency services and those that do visit PHC facilities are unwilling to admit and report such cases due to stigma and hesitation to report cases to health care providers. In 2015 and 2016 more than 900,000 refugees/migrants have transited through Serbia. UNFPA's support in Serbia was found to be a balance of international and local technical assistance. With UNFPA in North Macedonia support, in close cooperation, coordination and partnership with the Government in the time of the crisis, the National Plan for Preparedness and Response of the Health Sector in Emergencies was approved by the Government in April 2017.

Section 3. Efficiency

EQ 6.To what extent has UNFPA made good use of its human, financial and technical resources, and has used an appropriate combination of tools and approaches to pursue the achievement of the results defined in the UNFPA programme documents?

EQ6.A Assumption 1: UNFPA has made good use of its human, financial and technical resources to pursue the achievement of results defined in UNFPA programme documents.

EQ6.B Assumption 1: UNFPA has used an appropriate combination of tools and approaches to pursue the achievement of the results defined in the UNFPA programme documents.

EQ6.B Assumption 2: UNFPA CPs have expended resources to achieve outputs at a level that is consistent with standard norms for the cost of implementing program activities in each of the four program areas.

NB: The detailed listing of key assumption questions addressed below are shown in Annex 2.

Use of human, financial and technical resources: In all four countries/territory, there was an appreciation of the efficiency of UNFPA in organizing programmes with limited staff. For example, in Kosovo, there have only been two programme staff working in the UNFPA office and overall efficiency of the programme is considered very high. Stakeholders in BiH supported the UNFPA for ensuring a consistent focus in the area of SRH. However, UNFPA in BiH generally has a small programme and limited funds. Similar findings were observed in Serbia and North Macedonia where mobilizing resources is a challenge and the UNFPA office should be more engaged in the future in order to generate them. (All of above findings are sourced from respective programme documents and Evaluation Matrices).

Use of an appropriate combination of tools and approaches to pursue the achievement of the results: UNFPA has been using an appropriate set of global and international documents and tools, adjusting them to the local country context with help of international and local consultants, and training local professionals to replicate knowledge gained. For example, in BiH, virtually all interventions, including family planning repositioning, clinical guidelines, maternal death surveillance, MISP, were based on internationally designed methodologies. In Kosovo, the utilisation of technical expertise (local and international) and utilisation of tools and products developed by WHO for MCH was positively rated. In Serbia, a variety of resources were used for producing guidelines, protocols and standards for delivery of integrated quality SRH services; this included the internationally developed MISP for reproductive health in crisis situations. North Macedonia has used global and international documents, and has cited a need for greater support from international staff to support implementation (All of above findings sourced from respective CPERs and Evaluation Matrices).

Use of financial Resources: Examples of expenditures to achieve outputs suggested that the four programmes were generally in line with standard norms for costs in SRH activities. For example, some efficiency calculations for CCSP in Kosovo at the level of output (number of people screened) showed that UNFPA spent about 11.7 USD for each woman that took part in the programme. Similar findings were presented for other programmes. For example, for UNFPA in Serbia, the average costs per participant for different type of trainings in SRH area are quite variable. ToT training costs were felt to be a bit high but justified. In North Macedonia it was concluded that UNFPA has used good planning for the resources related to consultancy/trainers/experts engaged. International expertise has been used to strengthen the capacity of national experts.

Section 4. Sustainability

EQ7 Are programme results sustainable in short and long-term perspectives? NB: 3 years or less = short term. More than 3 years = long term.

EQ7 Assumption 1: The UNFPA CP has supported programs that have results that can be sustained in the short- and long-term (up to three years and greater than three years).

NB: The detailed listing of key assumption questions addressed below are shown in Annex 2.

SRHR interventions have potential of becoming sustainable, but follow up actions are necessary to assure sustainability. In BiH, all interventions in the SRHR programme area have potential of being sustainable in the short term (3 years or less) and long term (greater than three years). For example, FP repositioning activities could have potential for sustainability given that knowledge has been transferred to a large number of family medicine doctors. However, it is uncertain to what extent these doctors will consistently use the knowledge gained, as this could depend on personal choices and enthusiasm (BiH CPER). Similarly, in Kosovo, the delivery of training programmes on YFHS, STI syndromic management and FP, can be maintained and delivered without UNFPA support only if these programmes become part of the regular

programme for PHC personnel and are financed by the MFMC or by the MoH. In Serbia, the programme activities for SRH were designed to be sustainable in at least a three-year perspective, as they presented an institutionalized response related to improvement of SRH (established guidelines, protocols, standards, mechanisms). However, certain parts of the UNFPA programme activities relate to providing support to the provision of reproductive and sexual health services in emergencies, according to the needs of most vulnerable population groups, such as migrant women. The durability and long-term sustainability of the UNFPA in North Macedonia supported SRH programme activities are ensured by the national ownership over the results of the process of updating the guidelines, policies and procedures by the key national stakeholders (such the MoH, Agency for Quality and Accreditation). However, UNFPA North Macedonia's intervention for Reproductive Health Commodity Security, technical assistance support extended by UNFPA to the Ministry of Health, has not achieved sustainability.

EQ8 To what extent have the partnerships established by UNFPA promoted the national ownership and sustainability of supported interventions, programmes and policies?

EQ8 Assumption 1: The UNFPA CP has succeeded in developing partnerships that promote the national ownership and sustainability of supported interventions, programmes and policies.

There is clear evidence of success in developing partnerships that promote national ownership and sustainability of supported interventions, programmes and policies. For example, UNFPA BiH has not signed formal partnership agreements with BiH authorities. However, by signing UNDAF documents, BiH authorities have confirmed their agreement with interventions and assistance of UN agencies in BiH, including UNFPA. In North Macedonia, from a sustainability perspective, based on self-reports of the partnership stakeholders, one the best performing SRH programmes is the partnership between the UNFPA and the Government/MoH plus Accreditation Agency. This clinically focused work on Effective perinatal care (EPC), in two major maternities in the country meets all major sustainability requirements: national ownership, building national expertise in a high priority area of effective perinatal care (EPC).

4.2. Youth and adolescents

Section 1. Relevance

EQ1. To what extent is the UNFPA programme (i) adapted to the needs of women, adolescents and youth, people at risk of HIV infections, disabled and older persons, and Roma, (ii) and in line with the priorities set by the international and national policy frameworks, (iii) aligned with the UNFPA policies and strategies and the UNDAF as well as with interventions of other development partners? Do planned interventions adequately reflect the goals stated in the UNFPA Strategic Plan?

NB: The detailed listing of key assumption questions addressed below are listed above in Section 4.1 under each heading. They are also shown in Annex 2.

There are numerous examples for how all four programmes were adapted to the needs of various client populations and in line with international and national policy frameworks for youth and adolescents. In BiH, three desired outputs of UNFPA Strategic Plan 2018-2021 target youth and adolescents, including girls, and the BiH CPD 2015-2019 (2020) reflects these priorities. The relevance of the UNFPA programme in Kosovo in the formal education sector is very high given that the content about sexual and reproductive health has been introduced into the educational curriculum for the first time and their implementation has started recently. The current UNFPA programme initiatives in Serbia on Youth and Adolescence are completely aligned with UNFPA policies and strategies, as well as global priorities, including ICPD Programme of Action. North Macedonia CSE is consistent with the SP 2014-2017 Outcome 2 – Output 6,

with the UNFPA business model, and with the CPD Outcome 2 - Output 1 and it builds on the wealth of information provided by the UNFPA supported research.

Important gaps were flagged in the programme reports, however. The needs of youth in BiH are taken into account generally, but limited attention is given to those most at risk despite explicit reference from the 2015-2019 (2020) CPD. There is evidence that the UNFPA BiH programme has been adapted to some extent to different needs of different population groups, such as youth, but not to marginalized and vulnerable populations. The desk research of available documents and stakeholder interviews for North Macedonia indicate that the particularly vulnerable A&Y group, young adolescent girls, have not been addressed by the UNFPA programmes as a target group. The evidence suggests that, there has not been concerted action on the part of UNFPA toward institutionalization of comprehensive gender sensitive and age appropriate sexuality education (CSE) in the North Macedonian education system. The small UNFPA North Macedonia CO is not fully equipped to move forward on these complex activities. There is an indication that additional regionally based expertise could be helpful.

EQ2. To what extent has the programme office been able to respond to changes in the national development context and, in particular, to the aggravated humanitarian situation in countries/territory?

Given that the primary focus of these actions was for services for women rather than youth, most of these issues are presented above in the SRH section. The effective response of three of the four programme offices (BiH, Serbia, and North Macedonia) to aggravated humanitarian situations was clearly illustrated by actions taken when these UNFPA offices managed to rapidly respond to the changes which occurred during 2015 at the outset of the migrant/refugee crisis caused by the massive movements of refugees and migrants, (women, girls, men and boys) seeking refuge in Europe from the ongoing armed conflict and/or eruption of violence in their societies. Kosovo was not part of the migration routes taken and did not need to respond. The FBIH resource pack contains materials for youth in crisis. According to the results of the interviews with the key stakeholders and review of relevant programme documents, UNFPA in Serbia responded very well to an aggravated humanitarian situation (migrant crisis) in the Youth and Adolescents focus area. UNFPA in Serbia was among the first to recognize that migrant men and boys might be at an increased risk, which led to an extension of the Standard Operating Procedures for Prevention and Response to gender based violence among refugees and migrants.

Section 2. Effectiveness

EQ3. To what extent have the intended programme outputs been achieved? To what extent did the outputs contribute to the achievement of these planned outcomes: (i). increased utilization of integrated SRH Services by those furthest behind, (ii). increased the access of young people to quality SRH services and sexuality education.

The overall pattern of achievements of outputs for the four programmes is mixed for increased access of young people to quality SRH services and sexuality education. For example, UNFPA in BiH has partly achieved the outputs related to youth policy drafting and adoption and introducing comprehensive sexuality education in schools; it has fully met the targets related to addressing child marriage, while peer education programmes were stopped due to lack of sustainability prospects. There is no evidence that number of SRH peer education clubs increased (target 1), while the drafting and adoption of Youth policy was partly achieved (target 2). When it comes to support to development of policies that address youth and adolescent needs, UNFPA supported the drafting of youth policies for RS and FBIH, (that is, the Youth policy RS 2016-2020 and Strategy for Youth FBiH 2016-2020). RS successfully adopted the Youth policy in 2016. Introducing comprehensive sexuality education into schools was partly achieved (target 3). However, UNFPA's plans to replicate CSE integration into school curricula across the country have not

been ambitious enough. The target set in the CPD 2015-2019 is 13 percent of secondary schools (which was later changed to primary schools), and the current coverage (meaning all primary schools in Sarajevo Canton and Bosnian Podrinje Canton out of all primary schools in BiH) is 5.61%, hence partly achieved.
In Kosovo, there has been significant progress with the introduction of Comprehensive Sexuality Education (CSE) within the formal education system. Draft Manuals for Teachers have been developed for all grades of pre-university education to facilitate the delivery of sexuality education in formal education. UNFPA has piloted a training programme for teachers of primary, lower and upper secondary education levels on sexuality education. Regarding the peer to peer education on SRHR, during 2013-2018 about 2,300 youth peer educators were trained (about 56 percent girls and 44 percent boys). Both focus group discussions and the results from the pre and post-tests confirm the knowledge increases of trainees due to the training. When it comes to transmitting the knowledge to their peers, however, trainees were not able to transmit their knowledge beyond their close friends. As such, coverage of peer education is expected to be low compared to the overall size of the targeted age group. For Serbia, the planned number of quantified indicators per year was achieved. An example for this output achievement is the localization of SDGs, which was initiated in cooperation with the Ministry of Youth and Sports of Serbia. An output indicator related to number of civil society initiatives involving young men and boys in addressing gender-based violence has been also achieved, through creating local "Be a man" clubs and trainings, and BOYS on the MOVE life skills programmes. Three output indicators have not been achieved, however. A key output indicator, "Percentage of secondary schools that introduce comprehensive sexuality education aligned with international standards" has not been achieved yet, although a review of the current situation and status of sexuality education in secondary schools in Serbia was conducted in 2016, based on UNESCO's SERAT tools.

Finally, for North Macedonia, UNFPA has contributed to increased availability and use of SRH services for Adolescents and Youth by building national capacities for delivering youth friendly health services based on international standards. It should be noted, however, that there is no specific focus on the very young adolescent girls, which is required as per the goals stated in the UNFPA Strategic Plan. Apart from publishing a brief on child marriages (2013), UNFPA has not attached sufficient attention to the situation faced by girls at risk of child marriage. The evaluative evidence suggests that the UNFPA guidance regarding the incorporation of the comprehensive gender-sensitive and age-adjusted sexuality education into the national systems has not been sufficiently explored by the UNFPA. There has not been any concerted action on the part of UNFPA towards the goal of CSE for young adolescent girls, apart from some initial communications have been established between UNFPA and the Ministry of Education in 2018/2019. There is a lack of focus on the very young adolescent girls, which is required as per the goals stated in the UNFPA Strategic Plan.

To a limited extent, some of the intended outcomes have been achieved. For the BiH outcome, "Increased access of young people to quality SRH services and sexuality education," youth's access to sexuality education has certainly increased as the subject Youth Health has been formally integrated as obligatory educational content for the grades 6th to 9th in primary schools of the Bosnian-Podrinje Canton. While some progress has been made in training family medicine providers, a number of stakeholders have pointed out that integrating SRH services for youth into regular family medicine services is not an effective approach. In Kosovo, for CSE in formal education, it is too early to assess results, such as the ability of teachers to deliver qualitative and comprehensive sexuality education to all students as per the core curricula. For Kosovo CSE in non-formal educational settings, there are no data to measure the utilisation or application of the knowledge increases. Thus, it is not possible to assess any outcome level changes even within direct beneficiaries.

For Serbia, interviewed stakeholders and youth trainees were consistent in their assessment that the Outcome 2 of CPD 2016-20 related to the Adolescents and Youth focus area "Increased national capacity to conduct evidence-based advocacy for incorporating the human rights and needs of adolescents and youth in national laws, policies and programmes, including in humanitarian settings" has been achieved to great extent. The UNFPA Programme 2016-2020 implemented the IMAGES study for the first time (data were collected during 2017 and launched in 2018), and it may present a baseline for the indicators related to youth and adolescents. But, as interviewed stakeholders stated, it is too early to measure the impact of these activities. In North Macedonia, for the Adolescent & Youth – (SP 2014-2017) Outcome 2: "Increased priority on adolescents especially on very young girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health," the Outcome indicator 1: Number of laws and policies that allow adolescents (regardless of marital status) access to sexual and reproductive health services (Baseline: 0 Target: 2) has not been achieved.

It is unlikely that all progress towards outputs can be attributed to UNFPA interventions. The evidence in all four countries/territory supports the conclusion that the majority of progress toward intended outputs can be attributed to the UNFPA programmes. For example, UNFPA BiH has not been the sole assistance provider among donor and development agencies in the areas of Youth and Adolescents and pertinent activities. UNFPA's contribution to the drafting of the FBIH Youth Strategy constituted only a small portion of a larger project funded by the EU and implemented by NGOs KULT and OKC. In the area of CSE, however, while UNFPA has followed up on Association XY's previous work in Sarajevo Canton, the effects in Bosnian Podrinje Canton could be attributed largely to UNFPA programme. Expanding CSE in BiH is a drawn out process as each administrative area wants its own curriculum. In Kosovo, there is strong evidence to attribute a majority of progress on intended outputs to UNFPA interventions. For Serbia, the majority of progress related to achieving youth related outputs could be attributed to UNFPA activities, since none of the other agencies or institutions have a mandate and focus on increased priority to adolescents, particularly to work on increased availability of comprehensive sexuality education and sexual and reproductive health.

EQ 4 To what extent has UNFPA contributed to an improved emergency preparedness in BiH, of North Macedonia, Serbia, and Kosovo , and in the area of maternal health / sexual and reproductive health including MISP? (THIS QUESTION APPLIES TO ALL FOUR FOCUS AREAS; BUT PRIMARILY TO SRH) EQ5 To what extent has each office been able to respond to emergency situations in its Area of Responsibility (AoR), if one was declared? What was the quality and timeliness of the response? (THIS QUESTION APPLIES TO ALL FOUR FOCUS AREAS; BUT PRIMARILY TO SRH, ASRH AND GE)

Response to EQ4 and EQ5: There are relatively little work done for youth in the area or responses to emergency situations. This is addressed above in the SRH section.

Section 3. Efficiency

EQ 6.To what extent has UNFPA made good use of its human, financial and technical resources, and has used an appropriate combination of tools and approaches to pursue the achievement of the results defined in the UNFPA programme documents?

For all four countries/territory there was evidence that UNFPA has made good use of its human, financial and technical resources using an appropriate combination of tools and approaches. For BiH, UNFPA demonstrates financial discipline under the A&Y component, however this component has been

underfunded in relation to SRHR and GE components. For Kosovo, a very small portion of the total budget was dedicated for the CSE component of the work by the UNFPA. Nevertheless, given the potential for reaching out to all students and all grades in pre-university education, such expenditures could be considered as highly efficient once they start to be materialised. For Serbia, based on an analysis of key financial documents (mainly data from ATLAS and AWPs) related to the implementation of activities in the field of Youth and Adolescence, it can be firmly concluded that UNFPA in Serbia has made a good use of its human, financial and technical resources to pursue the achievement of results. The UNFPA in North Macedonia has made solid use of human, financial and technical resources related to the A&Y programme area. The main challenge of the programme is that it operates with very small amount of budget in comparison with other programme areas, especially with SRH.

Costs for training: When trainings related to the Youth and Adolescence focus area in Serbia are concerned, they were delivered by the implementing partner Center E8. According to the calculations provided by them, the average costs per participants were $50 per day, for three days training, including all costs such as travel, accommodation, food, workshop material, honorarium etc. These figures seem to be quite reasonable, much lower than expenditures for activities in other focus areas. UNFPA in Kosovo found that according to the financial reports submitted by the implementing agency, UNFPA spent about 70 Euro for training a teacher for sexuality education which is relatively low using the local expertise. For North Macedonia, based on desk research of the documents, in particular of the Annual work plans, it can be concluded that the UNFPA has used good planning for the resources related to consultancy/trainers/experts engaged.

Section 4. Sustainability

EQ 7. Are programme results sustainable in short and long-term perspectives?

There was a diverse range of estimates for sustainability over time for the four programmes. For example in BiH, policy development is expected to be sustainable in the short term (3 years or less) with the passage of the RS Youth Policy 2016-2020. Training of teachers in CSE is likely to ensure sustainability of results, as well as sexuality education tools, such as specifically designated website and smartphone application, if their maintenance is taken over by domestic partners. For Kosovo, the assessment of sustainability was based on two components, static and dynamic[63]. Static sustainability usually reviews the extent to which results achieved through the interventions will be maintained after UNFPA support is withdrawn. As such, the development of the Manuals will most likely have static sustainability at least in the mid-term (until 5 years), since Manuals will continue to be used by teachers without need for a major revision. Nevertheless, neither manuals nor trainings have the potential to reach dynamic sustainability. For example, the development of the Manuals does not have dynamic sustainability since there are no mechanisms in place other than UNFPA support that will continuously upgrade the Manuals developed for changing circumstances in the long run. For Serbia, results of the programmes related to SRH of adolescents and youth have been assessed as sustainable in the long term (greater than three years), especially those which are related to trainings aimed to young men, where attitudes and values toward gender equality and GBV were discussed ("Be Men" trainings). For North Macedonia, there was a positive finding for the sustainability of some aspects of the CPD A&Y Output 1. This is related to increased national capacities for delivering youth friendly health services based on international standards through

[63] Static sustainability reviews the extent to which results achieved through the interventions will be maintained after UNFPA support is withdrawn. Dynamic sustainability on the other hand, looks for system changes, i.e. whether functions and services supported by UNFPA and the production of the results will continue to be achieved beyond UNFPA support.

partnerships established by UNFPA with organizations of young key populations (YKP) at risk, such as people living with HIV (PLHIV), young sex workers, MSM and transgender people.

EQ 8. To what extent have the partnerships established by UNFPA promoted the national ownership and sustainability of supported interventions, programmes and policies?

There is evidence that all four of the UNFPA programmes have succeeded in developing partnerships that promote the national ownership and sustainability of supported interventions, programmes and policies for youth. In BiH, while UNFPA has not signed formal partnership agreements with authorities in BiH for A&Y, the ownership and enthusiasm of Bosnian-Podrinje Canton education authorities indicates continuous sustaining of the results achieved in CSE integration. For Serbia, UNFPA has absolutely promoted national ownership of supported interventions that were realized in collaboration with relevant ministry (Ministry of Youth and Sport) and strengthened civil society organizations initiatives. For North Macedonia, UNFPA has made significant contributions to the sustainability of its interventions in the A&Y focus area by increased national capacities for delivering youth friendly health services based on international standards and by selecting well placed, knowledgeable and reliable implementing partners.

4.3. Gender equality

Gender Equality Section 1. Relevance

EQ1. To what extent is the UNFPA programme (i) adapted to the needs of women, adolescents and youth, people at risk of HIV infections, disabled and older persons, and Roma, (ii) and in line with the priorities set by the international and national policy frameworks, (iii) aligned with the UNFPA policies and strategies and the UNDAF as well as with interventions of other development partners? Do planned interventions adequately reflect the goals stated in the UNFPA Strategic Plan?

NB: The detailed listing of key assumption questions addressed below are listed above in Section 4.1 under each heading. They are also shown in Annex 2.

In all four countries/territory there is strong evidence that the UNFPA programme is adapted to efforts to establish greater gender equity, working primarily with women and girls, with some lesser attention to working with young men to address gender and GBV. For example, in BiH, the programme has been adapted largely to the needs of women, including some groups of marginalized and vulnerable women, more specifically victims of GBV and Conflict-Related Sexual Violence (CRSV).[64] Work has also been done in BiH with civil society initiatives involving men and boys in gender and addressing gender-based violence. In Kosovo, since 2016 the UNFPA has supported non-formal educational and promotional activities including NGO organized training sessions for PHC personnel, university students and expecting fathers and mothers on positive fatherhood, the roles of fathers and mothers promoting gender equality norms. The UNFPA supported another NGO to provide peer education programmes for youth on gender equality topics including GBV based on the Programme Male Manual. In addition, in 2016 the UNFPA entered into an innovative partnership with Faith Based Organisations (FBOs) to raise awareness on GBV prevention and gender equality promotion and organised workshops with the Kosovo Islamic Community about the role of Islam in the prevention of GBV.

In Serbia, UNFPA integrated GBV prevention and protection measures and a response into national sexual and reproductive health programmes. A resource package for GBV was adapted for Serbia and ToT trainings for GBV were conducted by an IP to strengthen health professionals' capacities to deal with GBV.

[64] UNFPA in BiH jointly with FBO Interreligious Council BiH have developed and adopted a joint Declaration and Training Manual that all focused on alleviation of CRSV stigma, and provision of psychosocial support to survivors of CRSV

In addition, SOPs have been developed that are modelled against Minimum Standards for Prevention and Response to GBV in Emergencies. In North Macedonia, GBV-related services in emergency situations were implemented during the refugee/ migrant crisis in 2015. The UNFPA's advocacy resulted in drafting and approval of the first ever Standard Operating Procedure (SOP) for a multi-sectorial approach to GBV in emergencies, the Clinical Guidelines for Management of Victims of Sexual Violence, and a Protocol for the mobile SRH clinics.

All four of the UNFPA programmes are in line with the priorities set by the international and national policy frameworks for GE and GBV. For example, the UNFPA programme in BiH in the GE programmatic area has been aligned with international and national policy frameworks and adapted to the local context. In Serbia, GE and GBV activities are implemented as a cross cutting theme, according to the Country Programme Document (CPD) 2016-2020. GE and GBV are implemented consistent with UNFPA policies and strategies, as well as global priorities, including ICPD Programme of Action.

For all four countries/territory there is a good alignment between the UNFPA programme and the UNDAF as well as interventions of other development partners. For example, per the BiH UNFPA programme, the area of Gender Equality is aligned with priorities set in UNDAF for the periods 2010-2014 and 2015-2019(2020). In Serbia, there is a good alignment of the UNFPA GE and GBV activities and the national policy framework of the UNDAF 2016-2020. There are also close collaborations with other development partners in Serbia, including agencies involved in the Joint Programme Integrated Response to GBV.

The planned interventions in the four countries/territory related to GE and GBV clearly reflect the goals stated in the UNFPA Strategic Plan. As outlined by the BiH report, UNFPA's strategic goal globally has remained the same over two strategic planning cycles (2014-2017, 2018-2021). Under Outcome 3 of the Strategic Plan 2018-2021 it is stated "Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings." UNFPA's outputs relate to addressing gender-based violence for advancing gender equality and the empowerment of women and girls. In Serbia, UNFPA programmes in the GE and GBV focus area have been aligned with the priorities set by UNFPA Strategic Plan 2013-2017 and 2018-2021. Similar results are found for both Kosovo and North Macedonia.

EQ2. To what extent has the programme office been able to respond to changes in the national development context and, in particular, to the aggravated humanitarian situation in countries/territory?

In three of the four countries/territory, BiH, Serbia and North Macedonia, there was clear evidence of significant and successful response by the respective UNFPA programmes during aggravated humanitarian situations: for BiH, (floods in 2014 and migrant crisis in 2018), for Serbia (floods in 2014 and migrant crisis in 2015-2016), North Macedonia (floods and migrant crisis in 2015).

Gender Equality Section 2. Effectiveness

EQ3. To what extent have the intended programme outputs been achieved? To what extent did the outputs contribute to the achievement of these planned outcomes: mainstreaming of provisions to advance gender equality? (APPLIES TO ALL FOUR FOCUS AREAS)

All four countries/territory have made significant progress toward achievement of programme outputs for GE and GBV. For BiH, a selection of GE and GBV outputs was made: 1. tracking and reporting mechanism to follow up on the implementation of reproductive rights recommendations and obligations established at state and entities level (initiated but not yet implemented), 2. gender-based violence prevention, protection and response integrated into national sexual and reproductive health programmes (rolled out effectively) and, 3. number of civil society initiatives involving men and boys in addressing gender-based violence (partially achieved). In addition, there were some GE outputs not planned by the CPD. These unplanned outputs of UNFPA were responses to GBV/CRSV directed at alleviating stigma

against victims of CRSV and were considered successfully achieved.[65] In Kosovo, the results for pre- and post-tests showed that training activities related to GE and GBV had positive effects on trainees' perceptions towards gender equality and violence. Despite these positive results, the coverage of activities is low (about 1,000 people per year), which in turn means that the magnitude of the effect is also low. For Serbia, substantial progress related the outcome of gender equality and GBV could be attributed to UNFPA in Serbia as a single UN agency, but entire group of UN agencies are also involved in Joint Programme Integrated Response to GBV. For North Macedonia, the UNFPA supported activity in 2015 resulted in drafting and approval of several successful outputs, including the first ever Standard Operation Procedure (SOP) for multi-sectoral approach to GBV in emergencies, a clinical guideline on victims of sexual violence and a protocol for the mobile SRH clinics.

To a limited extent in all four countries/territory, intended outcomes have been achieved. For BiH, it was concluded that, overall, the intended outcomes pertaining to gender and GBV were for the most part achieved. Based on the review of outputs delivered, the mechanisms for a better response of the health sector to GBV/CRSV have been established and integrated in the health system. Although UNFPA in BiH is a partner on the Joint Programme on GBV/CRSV with three other UN agencies, UNFPA has been the sole technical assistance provider in the areas of health sector's response to GBV/CRSV and alleviating stigmatization. For this reason, the majority of progress on intended outputs can be attributed to UNFPA programme in BiH. For Kosovo, while there is some micro-evidence about output level changes at the level of trainees in UNFPA funded GE and GBV activities, there are no data to verify if the training leads to behavioural change (outcome level change) for trainees of gender equality trainings. Thus, it is not possible to assess any outcome level changes. For Serbia, the GE and GBV programme outputs were found to have been achieved for providing institutionalized support and advocacy for a strengthened health sector response to GBV, in both regular situations and emergencies and humanitarian crisis. For North Macedonia, the migrant/refugee crisis in 2015 triggered UNFPA's successful contributions to improved emergency preparedness for GBV, including MISP.

In all four countries/territory, it was found that UNFPA was responsible for the majority of progress for the intended outputs for GE and GBV. This is with the clear understanding that in all four countries/territory there were other institutional partners involved that supported many of the interventions.

EQ 4 To what extent has UNFPA contributed to an improved emergency preparedness in BiH, North Macedonia, Serbia, and Kosovo , and in the area of maternal health / sexual and reproductive health including MISP? (THIS QUESTION APPLIES TO ALL FOUR FOCUS AREAS; BUT PRIMARILY TO SRH)
EQ5 To what extent has each office been able to respond to emergency situations in its Area of Responsibility (AoR), if one was declared? What was the quality and timeliness of the response? (THIS QUESTION APPLIES TO ALL FOUR FOCUS AREAS; BUT PRIMARILY TO SRH, ASRH AND GE)

Regarding EQ4, all four UNFPA programmes made important contributions to emergency preparedness. All four UNFPA programmes made significant progress with implementing MISP and three of the four countries/territory (BiH, Serbia and North Macedonia) made very important contributions to emergency responses for floods and migration crises. Regarding EQ5, the three of the four countries/territory responding to emergency situations appear to have made high quality and timely responses to the floods and migration situations.

[65] 2015 - UNFPA BiH conducted Stigma Against Survivors of Conflict-Related Sexual Violence in Bosnia and Herzegovina. 2018 - IPs - CSO partners commenced their work on stigma alleviation through local level activism focusing on community values (12 locations in BiH) 2018 - CRSV Stigma Alleviation campaign was implemented in BiH.

Gender Equality Section 3. Efficiency

EQ 6.To what extent has UNFPA made good use of its human, financial and technical resources, and has used an appropriate combination of tools and approaches to pursue the achievement of the results defined in the UNFPA programme documents?

Overall, the four UNFPA programmes were found to have made good use of human, financial and technical resources, using an appropriate combination of tools and approaches to pursue the achievement of the GE results. For example, in BiH, while the GE component was somewhat unstable financially and the delivery of some GE results were not time efficient, given the number and reach of activities, the activities contributed significantly to the desired outcomes. The allocated percentage of the total yearly budgets for interventions in this programme area has ranged from 12 to 28 per cent of the overall budget. The execution of budgets has ranged from 87 to 100 per cent. The biggest amounts were spent on health sector's response to GBV, followed by stigma alleviation activities, and gender transformative actions. The financial information suggests that this area of the UNFPA programme in BiH has been the most resourced, as a result of additional UK project funding. Four members of staff worked on this component. When it comes to specific expertise for GBV and CRSV, UNFPA BiH staff had sufficient expertise. UNFPA in BiH has used global and international documents and tools, adjusting them for BiH's response to GBV.

Gender Equality Section 4. Sustainability

EQ 7. Are programme results sustainable in short and long-term perspectives?

There is evidence of both short and long-term sustainability for certain GE and GBV initiatives in all four programmes. For example, in BiH, some interventions in the programme area have potential of being sustainable in the short term and long term. This is because either policies or procedures were developed and endorsed and training was delivered (e.g. the resource package for health sector's response to GBV). Other interventions show poorer prospects for sustainability as they introduced practices that require further support to become mainstreamed into institutional and legal systems and have lasting effects (e.g. stigma alleviation activities). When it comes to work related to health sector's response to GBV, the fact that the resource packages were created in close cooperation with line ministries contributes to the likelihood of sustainability of these actions. Stakeholders have confirmed ownership of these interventions by relevant ministries. On top of this, sustainability is assured by the already existing policy framework in RS and FBiH pertaining to treatment of victims and perpetrators (laws, bylaws, strategies, international obligations). In Serbia, sustainability of interventions in the field of gender equality and gender-based violence eventually achieved a level where some interventions have been institutionalized. A number of national programmes and strategies were developed and adopted (SOPs and MISP related to GBV into the Draft National Health Sector Emergency response Plan), as well as sector-specific protocols (for health sector, by MoH), and protocols for cooperation of different institutions at the local level in case of GBV (for migrant populations as well). This was done in collaboration between Republic Institute of Public Health and Republic Health Insurance Fund, which is a process that will last for several years, typically 5-6 years.

EQ 8. To what extent have the partnerships established by UNFPA promoted the national ownership and sustainability of supported interventions, programmes and policies?

In all four countries/territory there were partnerships established by UNFPA that promoted national ownership and sustainability of GE and GBV activities. For example, although UNFPA has not signed formal partnership agreements with authorities in BiH, all planning has been done in cooperation with

authorities. The Health authorities take full ownership of resources developed as part of interventions related to health sector's response to GBV. Other institutions and organizations have been recognized as partners in UNFPA's Partnership Plans, including religious institutions and BiH Women's Football Team. GE and GBV stakeholders stated they valued their partnership and cooperation with UNFPA.

4.4. Population Dynamics

Population Dynamics Section 1. Relevance

EQ1. To what extent is the UNFPA programme (i) adapted to the needs of women, adolescents and youth, people at risk of HIV infections, disabled and older persons, and Roma, (ii) and in line with the priorities set by the international and national policy frameworks, (iii) aligned with the UNFPA policies and strategies and the UNDAF as well as with interventions of other development partners? Do planned interventions adequately reflect the goals stated in the UNFPA Strategic Plan?

NB: The detailed listing of key assumption questions addressed below are listed above in Section 4.1 under each heading. They are also shown in Annex 2.

For PD activities in the four countries/territory, there is evidence that the UNFPA programmes are adapted to the needs of key vulnerable populations, especially the older persons. In BiH, the UNFPA PD programme has been adapted to the needs of older persons. Importantly, for BiH, a review of documents and stakeholder interviews found that BiH does not currently have formally established population policies. BiH needs continued advocacy for population policy development and approval. UNFPA in Kosovo supports building institutional capacities for analysis of key population trends and their potential implications for public policies, such as the rate of people entering retirement age and migration levels. The UNFPA in Serbia collaborates with the Minister without portfolio in charge of demography and population policies supporting surveys to identify the needs of older people, and make recommendations for policy responses to enable people to age actively and in good health. Serbia still does not have an overreaching population policy that takes into account current and projected demographic trends, despite the fact that country is experiencing a process of demographic ageing, high migration and longer life expectancy[66]. The PD related activities in North Macedonia include work on the improvement of the statistical data, with focus on key demographic trends in fertility, ageing and migration.

The UNFPA programmes are in line with the priorities set by the international and national policy frameworks for PD. For example, three of the four countries/territory have supported actions related to the Madrid International Plan of Action on Ageing (MIPAA). BiH is a signatory of MIPAA and work on Strategies for Improving the Status of Older Persons in RS and FBiH was carried out. Both strategies have been created through a wide consultative process with interested stakeholders and UNFPA has greatly assisted this process. The UNFPA programme in Serbia worked on MIPAA training and assessment in 2014. UNFPA in North Macedonia has supported work on the MIPAA and the development of the National Action Plan to implement the Strategy for demographic development (2015-2024).

For all four countries/territory, there is a good alignment between the UNFPA PD programme and the UNDAF as well as interventions of other development partners. For example in BiH, UNFPA programme in the area of PD has been aligned with UNDAF 2010-2014 and UNDAF 2015-2019(2020) in their components related to Democratic Governance and Social Inclusion (evidence-based policies and work with older persons, respectively). UNFPA in Kosovo has been directly contributing to the achievement of

[66] There is a pronatalistic policy for Serbia (adopted in 2018) that takes into consideration all population issues. The focus of these population measures is to put an emphasis on increasing fertility (although emigration trends have larger effect on the overall number of population).

PD related outcomes of the UN Kosovo Team Common Development Plan (an UNDAF-like planning document). The programmatic activities on population dynamics relate to the application of evidence from population data by institutions to their policy making decisions (outcome 1.3.1). In Serbia and North Macedonia, UNFPA programmes in PD have been in line with the UNDAF 2016-2020.

There is evidence that the interventions for PD reflect the goals stated in the UNFPA Strategic Plan**.** The programme in BiH reflects the UNFPA's global strategic goal in relation to population dynamics and the need for creating evidence-based population policies.[67] The UNFPA Strategic Plans provide further guidance on how population dynamics should be monitored and used as evidence base, that is, by taking into account "the growth or decline of a population from high or low fertility, shifts in age structures, urbanization, and migration" (2014-2017), and also by shifting focus from historical data production from censuses, surveys and other similar statistical sources to "non-traditional data in order to fill gaps" (2018-2021). For Serbia, the PD activities reflect priorities set by the relevant international frameworks, primarily UNFPA SP 2013-2017 and 2018-2021. For North Macedonia, in the context of the most recent SP 2018-2021 Outcome 4, which refers to the need for improving national population data systems to map and address inequalities, UNFPA supported the adoption of the National strategy for sustainable development.

EQ2. To what extent has the programme office been able to respond to changes in the national development context and, in particular, to the aggravated humanitarian situation in countries?

In the area of PD, there are numerous examples where programme offices have been responsive to changes in national development context, however, the PD area is not focused on issues of aggravated humanitarian situations. One exception to this was during the floods in 2014 in BiH, two Health Ageing Centres were established in Modrica and Samac-Domaljevac, with the help of the first Healthy Ageing Centre in Sarajevo. The UNFPA supported a Survey of Effects of Centres for Healthy Ageing on Older Persons that was used for advocacy for centres in local communities.

Population Dynamics Section 2. Effectiveness

EQ3. To what extent have the intended programme outputs been achieved? To what extent did the outputs contribute to the achievement of these planned outcomes?

All four countries/territory have made significant progress toward achievement of programme outputs for PD. For BiH, three key outputs were selected to evaluate the effectiveness of the UNFPA CP under PD: 1. Government and statistical agencies have increased knowledge and skills to establish a migration surveillance system and to integrate it into the development and implementation of strategies and policies (partially achieved), 2. Officials of the Directorate for Economic Planning have the knowledge and skills to implement the Madrid International Plan of Action on Ageing through the European regional implementation strategy and through strategies for older persons (target set as "Parliamentary Assembly adopted the Madrid International Plan of Action on Ageing" achieved)., 3. Strengthened institutional capacity for the formulation and implementation of rights-based policies that integrate evidence on emerging population issues (low fertility, ageing and migration) and their links to sustainable development. UNFPA has commissioned a Population Situation Analysis, and has been building capacities

[67] It should be noted that one part of the programme in BiH, related to work on Strategies for Improvement of Status of Older Persons and support to Healthy Ageing Centres, does not seem to reflect the UNFPA Strategic Plans, including the current Strategic Plan for 2018-2021. Older persons are not featured as a target group in these plans, but the CPDs have planned outputs related to implementation of the Madrid International Plan of Action on Ageing. The drafting of Strategies for Improvement of Status of Older Persons in the two entities is considered by stakeholders to be very relevant intervention and in line with the domestic context.

on Population Projections, in cooperation with statistical institutions in BiH in 2019. For Kosovo, in relation to PD there is qualitative evidence that UNFPA efforts significantly strengthened capacities of Civil Registration Agency and Kosovo Agency of Statistics (KAS) in the production, analysis, and the dissemination of the population data. In the area of vital statistics, a crucial improvement was the resolution of the issue of underreporting death cases, which has been addressed through enhancing cooperation between the Civil Registry Agency and Faith Based Organizations. For Serbia's CPD 2016-2020 Outcome 4 Output 1, an output indicator is defined as "Number of policies developed at national level using secondary analysis of census data". This indicator has been already achieved by the adoption of the First National programme for sexual and reproductive health and rights. Finally, for North Macedonia there are two outputs that are used to assess PD efficacy. The first is Output indicator is: Functional national tracking system for monitoring and evaluation of implementation of population policies Baseline: No Target: yes. Concerning this indicator, it is not likely to be achieved as there is still no functional national system to monitor and evaluate the implementation of respective population policies. The second Output indicator is 2: Number of population databases accessible by users through web-based platforms that facilitate mapping of socioeconomic, gender and demographic inequalities. Baseline: 0; Target: 1. It is anticipated that this indicator will be achieved with the completion of the 2020 Census.

To a limited extent in all four countries/territory, intended outcomes have been achieved. For example, in BiH, the development of evidence-based national population policies has been achieved to a good extent. Given the delivery of outputs evaluated above, it can be concluded that the outcomes have been partly achieved. For Kosovo, qualitative evidence shows that UNFPA support strengthened the capacities of the Civil Registration Agency and KAS for the production, analysis, and the dissemination of population data. Similarly, the Population Statistics Division within the Department of Social/Population Statistics of KAS feels fully capacitated in demographic data analysis. The last Kosovo Population Projections (2017-2061) were produced by the Kosovo Agency of Statistics with external experts provided by UNFPA. In relation to vital statistics, UNFPA support resulted in the establishment of a working group to improve civil registration information flow. Through an MOU within this working group, the UNFPA facilitated data integration between the health system, which contains information on the number of births and deaths, and the civil registry. For Serbia it was felt to be too early to assess whether the intended programme outcome for the field of Population and Development has been achieved. An outcome indicator has been defined as the "Percentage of social development policies that are evidence-based (and respond to demographic trends)". For North Macedonia the assessment of progress is based on Outcome indicator 3: Number of new national and local development plans that consider population dynamics in setting development targets, Baseline: 0; Target: 1; Achieved: No. To date, the assessment is that it has not been achieved. In 2016, the National strategy for sustainable development was updated as a vision up to 2030. The process is still in an initial stages and there is a need for additional clarification of the UNFPA's programme activities related to the SDGs.

In all four countries/territory, it was found that UNFPA was responsible for the majority of progress for the intended outputs for Population Dynamics. This is with the clear understanding that in all four countries/territory there were other institutional partners involved that supported many of the interventions.

EQ 4 To what extent has UNFPA contributed to an improved emergency preparedness in BiH, North Macedonia, Serbia, and Kosovo, and in the area of maternal health / sexual and reproductive health including MISP? (THIS QUESTION APPLIES TO ALL FOUR FOCUS AREAS; BUT PRIMARILY TO SRH)

EQ5 To what extent has each office been able to respond to emergency situations in its Area of Responsibility (AoR), if one was declared? What was the quality and timeliness of the response? (THIS QUESTION APPLIES TO ALL FOUR FOCUS AREAS; BUT PRIMARILY TO SRH, ASRH AND GE)

For both of these questions the role of PD in response to emergency preparedness is extremely limited and therefore is not addressed.

Population Dynamics Section 3. Efficiency

EQ 6.To what extent has UNFPA made good use of its human, financial and technical resources, and has used an appropriate combination of tools and approaches to pursue the achievement of the results defined in the UNFPA programme documents?

In all four countries/territory, with the exception of a few years when UNFPA country programmes opted to support projects related to ageing, or surveys, such as the census or the MICS, the budgets for PD have been quite restricted compared to the other programme areas. Respondents in all four countries/territory reported that UNFPA programmes were very efficient in their use of funds for PD activities.

Population Dynamics Section 4. Sustainability

EQ 7. Are programme results sustainable in short and long-term perspectives?

There are clear cases made for short- and long-term sustainability in all four countries/territory. In BiH the Strategies for Improving the Status of Older Persons, when adopted by relevant authorities, could provide policy guidance on this issue for the next 10 years, but implementation will depend on the ability of domestic authorities to allocate sufficient resources for implementation. UNFPA work on data gathering in Kosovo is not considered sustainable, since all the surveys conducted so far rely heavily on UNFPA and other organisations' funds. There is a positive trend for the next MICS survey as the Kosovo authorities have decided to support MICS financially. Sustainability of UNFPA support for improvement of the vital statistics system in Kosovo is limited, given that certain Faith-Based Organisations are legally separate from the State Institutions, but they share responsibility within a MOU to play a role in the data gathering. The impact of UNFPA Serbia PD programme support has been at least short-term in its impact (3 or less years) for various studies conducted. In 2018 and 2019, UNFPA in Serbia supported the implementation of the MICS study jointly with UNICEF. UNFPA North Macedonia's extended technical assistance support for census related activities by SSO has potential sustainability, as does its $45,000 support for the MICS6 in 2019, a joint endeavour with UNICEF and SSO. UNFPA in North Macedonia supports building national capacity for formulation of comprehensive programmes in line with the Madrid International Plan of Action on Ageing. It also contributes to improvements in the national PD capacities, extending international technical assistance support for the 2020 Census (Census related communication campaign including a communications strategy).

.EQ 8. To what extent have the partnerships established by UNFPA promoted the national ownership and sustainability of supported interventions, programmes and policies?

In the area of PD there are examples of effective partnerships that permit national ownership and sustainability for interventions, programmes and policies. For example, BiH and North Macedonia, supported by UNFPA, have worked together on expanding a network of Healthy Ageing Centers based on the model developed in BiH. The HAC programme was submitted to the Government of North Macedonia to be budgeted in 2019. The MoLSP and the NGO PPH (Partnership for Public Health) from BiH, enabled and facilitated by UNFPA country offices in Skopje and Sarajevo, conducted capacity building events for practices and experience from BiH to be conveyed to counterparts in RoNM. The exchange of experiences and a handbook developed by the NGO PPH for establishing new healthy ageing centers supported opening of two new centers that serve as a nucleus of future network of healthy ageing centers in the region.

4.5 UNCT Cooperation and Value Added

Evaluation questions
EQ9 To what extent did UNFPA contribute to coordination mechanisms in the UN system at country level?
EQ10 To what extent does the UNDAF reflect the interests, priorities and mandate of UNFPA?
EQ11 To what extent did UNFPA contribute to ensuring programme complementarity, seeking synergies and avoiding overlaps and duplication of activities among development partners working in countries?
EQ12 What is the main UNFPA added value in the country/territory context as perceived by national stakeholders?

There is very clear evidence in all four countries/territory that the UNFPA programmes are making a consistent contribution to UN system coordination mechanisms at the country/territory level. For example, UNFPA in BiH has made consistent positive contributions to the consolidation and functioning of UNCT coordinating mechanisms (working groups and joint programmes) toward implementation of the UNDAF in each of the four programme areas. In Kosovo the UNFPA is an active member of all results groups pertinent to UNFPA's mandate. UNFPA in Serbia significantly and consistently contributes to the UNCT planning and coordination functions, through different mechanisms, such as attending working groups and participating in joint UNCT programmes. In North Macedonia, UNFPA has been an active contributor at all levels of UNCT coordination and to various joint activities and programmes under implementation within the inter-agency partnerships and cooperation.

In all four countries/territory there is clear evidence that the UNDAF reflects UNFPA's mandate, interests, and priorities. In BiH for example, UNFPA global mandates are being effectively implemented within the UNDAF in all four programme areas and UNFPA strategic priorities have been well represented in UNDAF. The latest 2017 UNDAF report for BiH, however, does not single out contributions of individual agencies any more, reporting on UNCT achievements as a whole. This change may affect the visibility of UNFPA's role within the UNCT in the future. UNFPA in Kosovo is one of the UN Agencies which has benefited the most from the joint programming that has emerged through coordination with UNKT. UNFPA is a part of almost every joint programme developed and implemented in Kosovo through various UN Agencies, Funds, and Programmes. According to the Development Cooperation Office, the UNFPA in Kosovo is one of the most active UN Agencies dealing with the coordination of efforts within UN Agencies. In Serbia, cooperation within the UNDAF/UN Partnership Framework reflects UNFPA's interests well; the UNDAF outcomes are clearly recognized and associated with the outcomes of UNFPA CPD 2016-20, as well as UNFPA SP 2017-2021.

There is evidence that the UNFPA programmes, for the most part, are avoiding overlaps and duplication of activities among development partners. For example, UNFPA BiH has cooperated with other UN agencies in delivery of activities and programmes, seeking synergies and avoiding overlaps and duplication of activities among development partners. But evidence on programme complementarity is inconclusive. There are at least two traditionally perceived areas of overlap with other UN agencies, with UNWOMEN in the sphere of gender equality, and with UNICEF in the sphere of youth. UN agencies in BiH have started to step into areas where UNFPA was so far almost an exclusive implementer. These areas include youth and ageing, which is why close coordination is necessary in order to ensure complementary actions. UNFPA in Kosovo actively contributes to organising regular planning, exchange and reporting meetings. Through these result group meetings, UNFPA coordinates closely with WHO and UNICEF on MCH issues and on data gathering for organizing MICS; this permits development of synergies, contributing to

programme complementarity to avoid overlaps. Another example illustrates how UNFPA in Kosovo has worked to ensure programme complementarity. A joint project on Justice 2020 and GBV (Support in Addressing Gender Based Violence Project), which is being implemented by UNFPA, UNICEF, UN Women, OHCHR, and UNDP, has allowed the UN Agencies that have different mandates to approach the issue from a different perspective. An example of how UNFPA in Serbia took care to avoid duplication of activities between different UN agencies and developmental partners is the case of preparation for a Demographic and Health Survey, for which UNFPA in Serbia prepared a position paper in 2015. UNFPA in Serbia abandoned this activity when the Serbia MICS study was announced and planned for 2019, to be led by UNICEF and a number of other national partners.

Regarding UNFPA's added value, in all four countries/territory, certain topics have made UNFPA quite recognizable and valued among UN and national stakeholders. In BiH, it was noted by a majority stakeholders that UNFPA addresses issues that no one else does - SRHR and PD. It was observed that no other UN agency in BiH has the mandate or capacity to lead on population matters. But UNFPA in BiH also addresses other generally neglected target groups, such as older persons. Stakeholders also valued UNFPA's practice to adapt its global standards and tools in particular areas, such as SRHR and GBV in emergencies, family planning and improving maternal health to the local context. In Kosovo, the added value of UNFPA lies in the fact that it is the only development partner active in certain areas. UNFPA in Kosovo is the only actor supporting the capacities of public institutions and NGOs in the field of SRHR. Similarly, UNFPA is the only organisation supporting population data analysis and projections. Without the support of UNFPA many studies, such as Kosovo Population Projection, would not be produced, nor would capacities be developed. Furthermore, the UNFPA in Kosovo acts as a facilitator, playing an intermediary role to bring stakeholders and organisations together. Similarly, for Serbia UNFPA is known for addressing issues that are not covered by other agencies, such as sexual and reproductive health and rights. UNFPA in Serbia is known for their ability to rapidly assess and respond to emergency situations, including activities on prevention and protection of gender-based violence, and gender equality with programmes that strengthen youth boys' perspective of it. Dealing with population issues and ageing are added value that UNFPA provides in Serbia. UNFPA in North Macedonia is recognized leading on important aspects of the SRH and rights, particularly for the most vulnerable groups of populations - young key population at risk, as well as Roma, people with disabilities. The UNFPA North Macedonia's noted value-added activities also include the GBV-related services performed by the UNFPA during and in the aftermath of the refugee/migrant crisis in 2015.

4.6 Assessment of UNFPA CP Plans: 1. Resource Mobilization 2. Partnership and 3. Communications/Advocacy

Item 1. Resource Mobilization: There are mixed levels of implementation and development of resource mobilization plans among the four programmes. The UNFPA in BiH drafted its Resource Mobilization Strategy for the period 2015-2019(2020) in the form of four annual resource mobilization plans (Please refer to BIH evaluation report Annex 3 for list of documents). These plans analyse the CP's financial structure and the donor environment. The plans map potential donors and identify actions in relation to these donors, for UNFPA independently, or in cooperation with other agencies. They identify clearly the key opportunities and obstacles in raising funds for UNFPA activities, noting primarily that the core resources allocated for the programme are insufficient to achieve set goals and fulfil set targets and indicators. It was noted that the programmatic areas that constitute the core of UNFPA's mandate, such as sexual and reproductive health and population policies have not been a focus of donor attention in BiH. Opportunities are noted for the donor interest in investing in gender equality and prevention of GBV. The

implementation of resource mobilization plans is regularly monitored by the UNFPA office. The resource mobilization plan for Kosovo was not submitted in time for review. For Serbia, the UNFPA programme for the period 2016-2020 has a clear and comprehensive plan for mobilization of additional resources that might be used as additional funding, besides core UNFPA funds. The resource mobilization plan has mapped a wide range of potential donors related to achieving all outcomes of the country programme. UNFPA in North Macedonia does not currently have a resource mobilizations plan. It would seem appropriate for the UNFPA in North Macedonia to draft such a plan to guide future efforts to raise funds.

Item 2. Partnership plans: There is considerable variation in the development of partnership plans among the four countries/territory. UNFPA in BiH drafts a Partnership Plan every year and they list all partners of UNFPA in delivery of specific interventions in line with the CPD objectives (please refer to BiH evaluation report Annex 3 for list of documents). The lists are exhaustive and include every institution that participates in UNFPA activities in any way. Each partner's role is described, as well as the expected outcome of partnerships. Plans are regularly monitored. Importantly, no partnership has been formalized between UNFPA in BiH and domestic authorities, which constitute a majority of partners. It could be argued that by signing the UNDAF, domestic authorities agreed to cooperation and partnership with UNFPA, as part of UNCT, in delivery of agreed products and activities. General practice in the BiH development environment has shown that signing of formal partnerships between individual organizations and institutions may actually slow down the beginning of delivery of interventions, a risk that should not be underestimated.

The UNFPA in Kosovo partnership plan, which was developed for the period of 2016-2020, consists of a listing of all types of partnerships. It would be more effective if the country team focused on establishing the critical or most important partnerships to achieve crucial results. The partnership template should not be partner-focused but rather result-focused. By focusing on key partnerships, it would be much easier for the country team to update the status of the plan by providing inputs (both narrative and indicator based) about the progress achieved and any need for revision. UNFPA Serbia's programme for the period 2016-2020 has a clear and comprehensive plan for partnerships with various organizations and institutions that constitute important partners in achieving outcomes of the CPD and UNFPA SP. Key indicators by year are established in this plan, with achievements reported in each COAR to track their effectiveness. The maintenance of this document by UNFPA in Serbia does not appear to generate much results in funding. UNFPA in North Macedonia prepares a partnership table with reported achievements for each year (See North Macedonia evaluation report, Annex 7. Partnership plan). According to the data from the table it can be concluded that UNFPA has partnerships with a wide range of partners.

Item 3. Communications/Advocacy: The development of advocacy plans has been done using very different approaches among the three of the countries/territory. No communications/advocacy plan was available for North Macedonia. UNFPA in BiH has drafted three advocacy plans on specific issues: comprehensive sexuality education, family planning and population development (please refer to Annex 3 of the BiH Evaluation Report for list of documents). Although they have advocacy elements and define goals and assumptions, these plans do not differ significantly from regular work plans for specific activities and do not plan for ambitious and persistent advocacy activities. Specific plans have not been created for interventions that have been met by considerable resistance of stakeholders (either due to their controversial nature, or lack of sufficient domestic capacities). For example, monitoring of maternal mortality and morbidity, integration of MISP into national preparedness plans, adoption of youth policies, stigma alleviation, or localization of SDGs. There is need for comprehensive advocacy planning for all

UNFPA BiH interventions across programmatic areas, with clear communication tactics and products. Apart from advocacy plans, communication plans are created every year, in line with AWPs, which could potentially result in overlapping activity. In Kosovo, an advocacy and communication plan was prepared on comprehensive sexuality education (CSE). The theme (Reaching political decisions on including sexuality education in school curricula) was chosen based on an advocacy priority area defined for the region. This was not considered to be a particularly useful approach, as the format was somewhat after the fact, representing just one issue.

In Serbia, a document titled the UNFPA Serbia Communication and Advocacy Plan 2015 defined key communication results within each of four outcomes of CPD: (1) communication of good results to keep the positive trend, (2) advocating for young people's SRH issues through evidence and data, and raising awareness on the prevention and protection from HIV/AIDS/STIs, (3) raising awareness on GBV issues and building network and partnerships, and (4) advocating and raising awareness on youth and aging issues. Different sets of tools, outputs and formats were planned to be used in order to achieve these communication results, such as formal trainings, developed guidelines, project reports, regular updates in social media and media coverage in general (website, Facebook, Twitter), reports of events, education theatre and focus group discussions, launching official statements i.e. press releases. Each focus area i.e. outcome is covered by carefully created messages that provide evidence and outline a future course of action needed to make changes toward achieving the ICPD agenda. In 2016, it was reported that UNFPA in Serbia and its activities were mentioned only six times in the media, and there were eight press clippings. In 2017, there was 43 mentions of UNFPA in media, and four press clippings (COAR 2016, COAR 2017). All press clippings were sent to Regional Office in a timely manner. The targeted number of annual CO advocacy and/or communication plans was reported to have been achieved.

CHAPTER 5: Cluster Evaluation Conclusions

5.1. Cluster Evaluation Strategic Conclusions

The following cluster-level conclusions were drawn from the conclusions from the four country evaluation reports and further analysis of data at the cluster level.

Cluster Strategic Conclusion 1: All four UNFPA programmes currently focus on too many outputs, many of which are focused outside the key interventions within UNFPA's core mandate and in so doing they have relatively low implementation efficiency. There is a clear need to reduce the number of activities to improve focus and efficacy.

5.2. SRH Related Conclusions

Cluster SRH Conclusion 1: There are ongoing problems with family planning service delivery in all four countries/territory, including a low prevalence of use of modern contraceptive methods, lack of accessibility and availability of contraceptives and a high reliance on abortions for unplanned pregnancy

Cluster SRH Conclusion 2: The evidence clearly suggests there is need for a more comprehensive UNFPA programmatic response for the following population groups considered particularly vulnerable in all four countries/territory: Roma, people with disabilities and adolescent girls.

Cluster SRH Conclusion 3: In all four countries/territory there has been some interest on the part of UNFPA in addressing cervical cancer, with the most significant progress made in Kosovo.

Cluster SRH Conclusion 4: Despite improvements in levels of maternal mortality and morbidity in all four countries/territory, trends in these measures are not consistently monitored over time to ensure progress continues to be achieved.

Cluster SRH Conclusion 5: All four countries/territory have demonstrated considerable progress in implementing the Minimum Initial Service Package (MISP) programme, especially in the context of the health sector response to emergencies and GBV.

5.3. Adolescence and Youth Related Conclusions

Cluster A&Y Conclusion 1: In all four countries/territory, the importance of expanding comprehensive sexuality education (CSE) in primary schools and high schools is very high given the potential of this type of formal education to provide all pre-university students with sexuality education throughout different grades of schooling.

Cluster Youth and Adolescence Conclusion 2: In all four countries/territory the role of men in achieving gender equality and zero tolerance to gender-based violence is considered important, and programmes have successfully involved young men and boys to improve SRH and address gender norms and gender-based violence.

Cluster Youth and Adolescence Conclusion 3: Awareness among youth on SRHR issues is low in all four countries and UNFPA has only made limited efforts to address this gap. Raising awareness about SRHR among youth could be achieved through development and use of applications for mobile devices that are freely available.

5.4. GE and GBV Related Conclusions

GE and GBV Conclusion 1: The UNFPA GE programme area has been mostly aligned with international and national policy frameworks and has been able to adapt to local context; the CPs have been adapted largely to the needs of women, including some groups of marginalized and vulnerable women, more specifically victims of GBV and CRSV. Service providers' capacities and competencies (in medical and psychosocial support institutions) to deal with GBV have been significantly improved due to the trainings they attended, as a part of the UNFPA supported programme. Additionally, non-traditional stakeholders (such as faith-based organizations and religious communities) have been trained to provide necessary psychosocial support and counselling to survivors of GBV and CRSV.

5.5. Population and Development Related Conclusions

Population and Development Conclusion 1: In all four countries/territory, national partners, notably the national agencies responsible for statistics, need to enhance their knowledge and their instruments for collection and dissemination of data relevant for improved national population statistics. National population data with improved quality are needed in all four countries/territory to allow development planning and to address the needs of marginalized and vulnerable populations for the allocation of resources and programmes.

Population and Development Conclusion 2: Essential current demographic data are missing in all four programmes to serve as evidence for future policy development. Three of the four countries/territory will be completing MICS6 surveys by 2019: Kosovo in 2019, Serbia in 2019 and North Macedonia in 2019. There was an expectation that BiH would complete a MICS survey in 2020, but for political reasons, UNICEF has decided not to support one. It is not clear if the negotiations for a MICS in BiH will resume.

CHAPTER 6: Cluster Evaluation Recommendations

The following recommendations correspond to the above conclusions and are complementary to the recommendations in the four country reports.

6.1. Cluster Evaluation Strategic Recommendations

Cluster Strategic Recommendation 1: All four UNFPA programmes should focus on fewer outputs that are focused on interventions within UNFPA's core mandates in order to get efficiency gains. It is recommended that UNFPA programmes in the four countries/territory focus primarily on two areas: SRHR and PD, both of which are well within UNFPA traditional mandate and do not overlap with other UN agencies. These two programme focus categories should be kept narrow in focus but can address specific target groups and focus areas, such as youth, marginalized populations, and women victims of GBV. Continued work on PD policy making and monitoring, with a focus on data, are extremely important and therefore recommended as a priority for all four countries/territory.
To: All Country Offices. **Priority level:** High. **Linked to** Strategic Conclusion 1.

6.2. SRH Related Cluster Recommendations

Cluster SRH Recommendation 1: All four countries/territory should continue and expand to work on family planning service delivery, including advocacy for MoH support for contraceptive procurement, to reduce unmet need and reliance on abortions for unplanned pregnancy.
To: All Country Offices. **Priority level:** High. **Linked to** SRH Conclusion 1.

Cluster SRH Recommendation 2: UNFPA programmes in all four countries/territory should adjust interventions to the needs of specific population groups, including marginalized and vulnerable groups (Roma, people with disabilities and young adolescent girls) and develop tailor-made interventions for these groups.
To: All Country Offices. **Priority level:** High. **Linked to** SRH Conclusion 2.

Cluster SRH Recommendation 3: The UNFPA programmes in all four countries/territory should focus on developing and supporting an economical approach for cervical cancer screening and treatment that can be gradually expanded to serve all parts of each country/territory.
To: All Country Offices. **Priority level:** Medium. **Linked to** SRH Conclusion 3.

Cluster SRH Recommendation 4: In all four countries/territory, UNFPA should continue to support work related to maternal health, and in particular work on maternal mortality and morbidity surveillance.
To: All Country Offices. **Priority level:** Low. **Linked to** SRH Conclusion 4.

Cluster SRH Recommendation 5: In all four countries/territory, UNFPA should continue to support work related to MISP to ensure that it is fully functional in time of need within each country's response system for health emergencies.
To: All Country Offices. **Priority level:** Medium. **Linked to** SRH Conclusion 5.

6.3. Adolescence and Youth Related Cluster Recommendations

Cluster A&Y Recommendation 1: In all four countries/territory UNFPA programmes should support efforts to work within public primary and high schools to support the development of effective CSE curricula and training of appropriate types and quantity of teachers for expansion of CSE in cooperation with national educational systems. These efforts may require additional expertise from the Regional Office to assist the COs on a short-term basis to support advocacy, policy dialogue and technical assistance with the pertinent Government agencies.
To: All Country Offices. **Priority level:** High. **Linked to** A&Y Conclusion 1.

Cluster Youth and Adolescence Recommendation 2: In all four countries/territory, UNFPA should consider implementing programmes that address SRH, gender stereotypes and GBV among young men and scale up these programmes as much as feasible. There should be a regional review of male oriented programme initiatives within the four nations in order to develop a four-nation collaboration effort. Each of the four countries should develop male oriented program efforts that are narrowly focused and provide the best opportunity to capitalize on prior local and regional experience.
To: All Country Offices. **Priority level:** Medium. **Linked to** A&Y Conclusion 2.

Cluster Youth and Adolescence Recommendation 3: Develop or assist government institutions and NGO organizations to develop and maintain of a mobile phone application for SRHR is important step that has potential to achieve the intended impact if widely used by young people. UNFPA should consider developing and implementing applications for mobile devices for young people.
To: All Country Offices. **Priority level:** Medium. **Linked to** A&Y Conclusion 3.

6.4. GE and GBV Related Cluster Recommendations

GE and GBV Recommendation 1: UNFPA programmes in all four countries/territory should remain active in the field of GE and GBV and continue supporting capacity building of health professionals throughout their respective countries/territory. GE and GBV activities should be discontinued as a separate initiative; they should be continued as part of upgrading the capacities of health professionals through future UNFPA supported SRH initiatives.
To: All Country Offices. **Priority level:** Medium. **Linked to** GE and GBV Conclusion 1.

6.5. Population and Development Related Cluster Recommendations

Population and Development Recommendation 1: In all four countries/territory the UNFPA programme should continue to extend advisory support to the national partners, notably the national agencies responsible for statistics, to enhance knowledge and the instruments for collection and dissemination of data relevant for improved national population statistics.
To: All Country Offices. **Priority level:** High. **Linked to** Population and Development Conclusion 1.

Population and Development Recommendation 2: UNFPA programmes in each country/territory need to support and participate in the MICS6 activities (or in the case of BiH, consider providing support for a DHS or other type of survey) as much as feasible to ensure the key demographic data are collected for UNFPA programme development and monitoring.
To: All Country Offices. **Priority level:** High. **Linked to** Population and Development Conclusion 2.

References

Overview references

Cemerska, Rajna and Sara Osmani. Final Report for Country Programme in North Macedonia. August 2019.

Djikanovic, Bosilijka and Zeljka Stamenkovic. Final Report for Country Programme in Serbia. April 2019.

Karadjinovic, Nina and Sanela Muharemovic. Final Report for Country Programme in Bosnia and Herzegovina. September 2019.

Koro, Levent and Sami Uka, Alban Fejza. Final Report for Country Programme in Kosovo. March 2019.

UNFPA. The Terms of Reference for the Cluster Evaluation of the Country Programmes for Bosnia and Herzegovina, The former Yugoslav Republic of Macedonia, the Republic of Serbia and Kosovo. (See Annex 1 of this report). 2018.

UNFPA Independent Evaluation Office. Handbook: How to Design and Conduct a Country Programme Evaluation at UNFPA. 2013.

United Nations Evaluation Group. UNEG Ethical Guidelines for Evaluation. Retrieved from United Nations Evaluation Group: http://www.unevaluation.org/document/download/548. 2008.

United Nations Evaluation Group Task Force. UNEG Handbook for Conducting Evaluations of Normative Work in the UN System. From United Nations Evaluation Group: http://www.uneval.org/document/detail/1484. 2013.

Clark, S. Design Report for UNFPA Cluster Programme Evaluation for: Bosnia and Herzegovina, The former Yugoslav Republic of Macedonia, The Republic of Serbia and Kosovo. Draft 0.7. 13 December 2018.

UNFPA. UNFPA Strategic Plan 2018-2021 and annexes. UNFPA, New York: 5 to 11 September 2017.

UNFPA. UNFPA Strategic Plan 2014-2017 and annexes. UNFPA, New York: 2013.

UNFPA and International Planned Parenthood Federation - European Network. Key Factors Influencing Contraceptive Use in Eastern Europe and Central Asia. 2012.

References pertaining to Bosnia and Herzegovina

UNFPA BiH. Country Programme Document for Bosnia and Herzegovina 2010-2014. 2014.

UNFPA BiH. Country programme document for Bosnia and Herzegovina 2015-2019. 2015.

UNFPA BiH. Annual Work Plans for 2014,2015, 2016, 2017 and 2018.

UNFPA BiH. Country Office Annual Reports for 2013, 2014, 2015, 2016, 2017, 2018.

UNFPA BiH. Project Monitoring Reports for 2013, 2014, 2015, 2016, 2017, 2018. (system-generated) 2018 and 2019.

One United Nations Programme and Common Budgetary Framework Bosnia and Herzegovina 2015-2019: United Nations Development Assistance Framework. 2015.

UNFPA BiH. Stigma against Survivors of Conflict-Related Sexual Violence in Bosnia and Herzegovina - Research Summary. Sarajevo: UNFPA. 2015.

UNFPA BiH. Survey on Perceptions, Attitudes and Opinions of Medical and Social Services Professionals towards Gender Based Violece and Conflict Related Sexual Violence Issues and Survivors. Sarajevo: UNFPA. 2014.

UNFPA BiH. UNFPA Activities on Combating Sexual Violence in Conflict. Sarajevo: 2012.

United Nations Country Team BiH. Common Country Assessment Bosnia and Herzegovina 2013. 2013.

United Nations Population Fund. Programme of Action. Adopted at the International Conference on Population and Development, Cairo, 5-13 September, 1994. United Nations Population Fund. 2004.

Executive Board of the United Nations Development Plan and of the United Nations Population Fund. United Nations Development Fund: Country programme document for Bosnia and Herzegovina (DP/FPA/CPD/BIH/2) . New York. 2014.

Executive Board of the United Nations Development Plan and of the United Nations Population Fund.). United Nations Population Fund: Draft country programme document for Bosnia and Herzegovina. (DP/FPA/DCP/BIH/1) . New York. 2009, April 16.

Institute for Statistics of FBiH. (2018). Abbreviated Approximate Life Tables, Federation of Bosnia and Herzegovina, Sarajevo: Institute for Statistics of FBiH. 2018.

Gender Equality Agency of Bosnia and Herzegovina, Ministry of Human Rights and Refugees of Bosnia and Herzegovina. *Gender Action Plan of Bosnia and Herzegovina (GAP).* (S. Filipović-Hadžiabdić, A. Vuković, & S. Krunić, Eds.) Gender Equality Agency of Bosnia and Herzegovina. 2007.

Institute for Statistics of FBiH. Statistical Yearbook. Sarajevo: Institute for Statistics of FBiH. 2017.

Institute for Statistics of FBiH. Statistical Yearbook 2018. Sarajevo: Institute for Statistics of FBiH. 2018.

Ministry of Security of Bosnia and Herzegovina. Sector for Immigration. Bosnia and Herzegovina Migration Profile for the year 2017. Sarajevo: Ministry of Security of Bosnia and Herzegovina. 2018.

proMENTE social research. Youth Views on Comprehensive Sexuality Education as a Part of Formal Education. Sarajevo: UNFPA. 2017.

Ramić-Čatak, A., Stoisavljević, S., Šabanović, E., Knežević, G., & Bašić-Ćatić, S. (2016). Survey of Effects of Centres for Healthy Ageing on Older Persons. Sarajevo: UNFPA. 2016.

The Ministry for Human Rights and Refugees of Bosnia and Herzegovina and the Agency for Statistics of Bosnia and Herzegovina. Multiple Indicator Cluster Survey (MICS) 2011-2012, Bosnia and Herzegovina: Roma Survey. Sarajevo: UNICEF. 2013.

UNDP. Human Development Indices and Indicators: 2018 Statistical Update, Bosnia and Herzegovina. 2018.

UNFPA. 2017 Annual Report - Bosnia & Herzegovina. Not published. 2018.

United Nations. Office of the Resident Coordinator, Bosnia and Herzegovina. One UN Programme Bosnia and Herzegovina 2015-2019. 2017-2018 Joint UN Work Plan. Empowerment of Women (Pillar 4). Not published. 2016.

United Nations. Office of the Resident Coordinator, Bosnia and Herzegovina. One UN Programme Bosnia and Herzegovina 2015-2019. 2017-2018 Joint UN Work Plan. Rule of Law and Human Security (Pillar 1). Not published. 2016.

United Nations. Office of the Resident Coordinator, Bosnia and Herzegovina. One UN Programme Bosnia and Herzegovina 2015-2019. 2017-2018 Joint UN Work Plan. Social Inclusion: Education, Social Protection, Child Protection and Health (Pillar 3). 2016.

United Nations. Office of the Resident Coordinator, Bosnia and Herzegovina. One UN Programme Bosnia and Herzegovina 2015-2019. Joint Work Plan for the Years 2015-2016. Empowerment of Women (Pillar 4). 2014.

United Nations. Office of the Resident Coordinator, Bosnia and Herzegovina. One UN Programme Bosnia and Herzegovina 2015-2019. Joint Work Plan for the Years 2015-2016. Rule of Law and Human Security (Pillar 1). 2014.

United Nations. Office of the Resident Coordinator, Bosnia and Herzegovina. One UN Programme Bosnia and Herzegovina 2015-2019. Joint Work Plan for the Years 2015-2016. Social Inclusion: Education, Social Protection, Child Protection and Health (Pillar 3). 2014.

Clark, S., Golemac Powell, A., & Durmo, E. UNFPA Country Programme Evaluation. UNFPA BiH. 2013.

References Pertaining to North Macedonia

UNFPA North Macedonia and Implementing Partners. Annual Work plans for the period 2012-2018.

UNFPA North Macedonia. Annexes from the UNFPA Annual Reports for 2013, 2014, 2015, 2016, 2017, 2018.

UNFPA North Macedonia. Communication Plans and Reports for the period 2014-2018.

UNFPA North Macedonia. Partnership Plans and reports for the period 2014-2018.

UNFPA North Macedonia. Joint Project on Reducing Maternal and Newborn Mortality. UNFPA and the Government (Ministry of Health and Agency for Quality and Accreditation of Health Institutions) Progress Report prepared by UNFPA North Macedonia. September - October 2018.

North Macedonia MoH. SRH Action Plan, Adopted by the government - 11.09.2018. 2018.

Jeckaite, Dalia. Report on WHO Effective Perinatal Care Training Course In Skopje, Macedonia. 24 September-05 October, 2018. Report prepared for UNFPA CO of FYRO Macedonia by Dalia Jeckaite RM BsRN MPH, midwife WHO consultant, Panevezys, Lithuania. 2018.

Haug, Werner. The 2020 Census in the Former Yugoslav Republic of Macedonia: preparations, challenges and UNFPA-MAKSTAT cooperation. Draft Report of the expert mission on population data and census policies, 17-21 September 2018.

United Nations Country Team Skopje. Partnership for Sustainable Development United Nations Strategy for 2016-2020. United Nations Country Team Skopje. Skopje, 24 October 2016.

UNFPA North Macedonia. Country programme document for the Former Yugoslav Republic of Macedonia. United Nations Population Fund. Five years (2016-2020). 2016.

References pertaining to Serbia

UNFPA Serbia. Country Office Annual Report (COAR) 2013, 2014, 2015, 2016, 2017.

UNFPA Serbia. Annual Work Plan (AWP) 2013, 2014,2015,2016,2017,2018.

UNFPA Serbia. Standard Progress Report (SPR) 2013, 2014, 2015, 2016, 2017.

UNFPA Serbia. List of Atlas Projects Serbia.. August 15, 2018.

UNFPA Serbia. Serbia Resource Mobilization Action Plan 2016-2020. UNFPA Serbia, 2015.

UNFPA Serbia. Partnership plan 2016-2020. UNFPA Serbia, 2015.

UNFPA Serbia. Communication and Advocacy Plan 2015. UNFPA Serbia, 2015.

UNFPA Serbia SRH Emergency Report. UNFPA Serbia. April 2016.

United Nations Common Country Assessment for the Republic of Serbia. Belgrade, UNCT: June 2015.

“Evaluative Evidence” Using Light Methodology of the UNFPA Programme Framework of Assistance to theGovernment of the Republic of Serbia (2011-2015). Belgrade: March 2015.

United Nations Development Partnership Framework 2016-2020. Government of the Republic of Serbia and United Nations Country Team in Serbia. Belgrade: May 2017.

United Nations Country Partnership Strategy Republic of Serbia 2011-2015. United Nations Development Assistance Framework (UNDAF) 2011-15. Belgrade: June 2010.

Statistical Office of the Republic of Serbia. Statistical Yearbook 2018. Available at: http://publikacije.stat.gov.rs/G2018/Pdf/G20182051.pdf

Republic of Serbia. National Program for Protection and Promotion of Sexual and Reproductive Health of citizens Republic of Serbia. Official Gazette Republic of Serbia 120/2017. 2017.

Republic of Serbia. National Youth Strategy for the period of 2015-2025. Official Gazette Republic of Serbia22/2015.

Republic of Serbia. The Strategy of social inclusion of Roma in Republic of Serbia for the period from 2016 to 2025. Official Gazette Republic of Serbia 26/2016.

Republic of Serbia. National Strategy for Prevention and Elimination of Violence against Women in the Family and in Intimate Partner Relationships (2011-2015). Official Gazette Republic of Serbia 27/2011.

Republic of Serbia. National Strategy on Gender Equality for the period 2016-2020. Official Gazette Republic of Serbia 4/2016.

Thomas, Robert and UNFPA Serbia. BOYS on the MOVE. Assessing the situation and needs of unaccompanied (specifically male) adolescent migrants and refugees in Serbia, October 2017.

Center E8. “Be a Man” clubs. In: Advancing GE and strengthening capacities to prevent GBV among key populations in Serbia. Final Report. Center E8, 2015.

Center E8. “Be a Man” project. Q1 narrative report. Center E8. Belgrade: January - March 2017.

Thompson, Robert and Alexios Geogralis. Youth Policy and Comprehensive Sexuality Education international consultant. UNFPA MISSION REPORT. (Educational Methodology international consultants). 11 December 2017.

Sancar, Annemarie. Assessment of the situation and challenges faced by the service providers in asylum transit reception centers in the Republic of Serbia. UNFPA, Bern and Belgrade: December 2017.

UNFPA Serbia. and Danish Refugee Council. Strengthening access and quality to family planning and reproductive health services for all. Final Report. UNFPA and Danish Refugee Council, 2017.

United Nations Serbia. Coordinated Response To Floods Recovery. Portfolio of International Financial Institutions and the UN Country Team's ongoing programming efforts in Serbia. United Nations Serbia, 2014.

Jevtić, Marija. Assessment of the situation on the field with an analysis of post-flood services provided. Report prepared by Dr Marija Jevtić. Inter-Agency Standing Committee (IASC) and UNFPA, 2014.

References pertaining to Kosovo.

UNFPA Kosovo. Annual Work Plans 2014, 2015, 2016, 2017, 2018.

UNDP Kosovo. Kosovo Human Development Report. 2012.

Kosovo Agency for Statistics (KAS) & UNICEF Multiple Indicator Cluster Survey (MICS), 2013-2014; Monitoring the Situation of Children and Women. Summary Report. 2015.

KAS, Kosovo Population and Housing Census 2011.

KAS, Assessment of the Kosovo Population for 2015.

KAS, Kosovo Population Projection 2017 -2061.

KAS: Health Statistics for 2016.

Kosovo MoH. Sectoral Strategy for Health, 2017-2021. 2016.

Kosovo MoH. Strategic Plan for Mother and Child Health and Reproductive Health, Draft Plan for the period 2018-2021. 2019.

Ombudsperson Institution of Kosovo (OiK). Sexual and Reproductive Health and Rights in Kosovo: A reality beyond the Law. A report on the National Assessment of Sexual and Reproductive Health and Rights by the Ombudsperson Institution of Kosovo. 2016.

ANNEXES

Annexes of Volume 1 Cluster Evaluation Report
Annex 1: The Terms of Reference for the Cluster Evaluation

Volume 2: UNFPA Country Evaluation Report of Bosnia and Herzegovina
Volume 3: UNFPA Country Evaluation Report of North Macedonia
Volume 4.UNFPA Evaluation Report of Kosovo
Volume 5 UNFPA Country Evaluation Report of Serbia

Annex 1 Terms of Reference

The Terms of Reference for the Evaluation of the Programmes for Bosnia and Herzegovina, The Republic of North Macedonia, the Republic of Serbia and Kosovo

A. INTRODUCTION

The United Nations Population Fund (UNFPA) is the lead United Nations sexual and reproductive health agency for ensuring rights and choices of all. The strategic goal of UNFPA is to achieve the three transformative results: ending unmet need for family planning, ending maternal death, and ending violence and harmful practices against women and girls. In pursuing its goal, UNFPA has been guided by the International Conference on Population and Development (ICPD) Programme of Action (1994), the Millennium Development Goals (2000) and the 2030 Agenda for Sustainable Development (2015).

The Terms of Reference (TOR) lay out the objectives and scope of the evaluation, the methodology to be used, the composition of the evaluation team, the planned deliverables and timeframe, as well as its intended use. The Terms of Reference also serve as a basis for the job descriptions for the evaluation team members.

The ToR is written by the evaluation managers of UNFPA offices, Bosnia and Herzegovina, The Republic of North Macedonia, the Republic of Serbia and Kosovo, with the support of the Eastern Europe and Central Asia Regional Office Monitoring and Evaluation Adviser. Final ToR is approved by the Regional Office for Eastern Europe and Central Asia on behalf of Evaluation Office before the launch of the evaluation.

Bosnia and Herzegovina, The Republic of North Macedonia, the Republic of Serbia and Kosovo, are UNFPA offices that form one of the administrative clusters of the Eastern Europe and Central Asia region. The programmes of these offices have the harmonized programme cycle ending in 2020, therefore the cluster programme evaluation of all four programmes is planned as part of the UNFPA quadrennial evaluation plan (DP/FPA/2018/1) approved by the Executive Board.

The overall purpose of the cluster evaluation is to: a) demonstrate accountability to stakeholders on performance in achieving development results and on invested resources, b) support evidence-based decision-making, and c) contribute important lessons learned to the existing knowledge base on how to accelerate the implementation of the ICPD Programme of Action.

The primary users of this evaluation are the decision-makers in cluster countries/territory where UNFPA operates, including the organization as a whole, government counterparts, and other development partners. The UNFPA Regional Office for Eastern Europe and Central Asia and UNFPA Headquarters divisions, branches and offices will also use the evaluation as an objective basis for programme performance review and decision-making.

The evaluation will be managed by a steering committee consisting of UNFPA evaluation managers in each country/territory with guidance and support from the UNFPA Regional Advisor on Monitoring and Evaluation and the UNFPA Evaluation Office, and in consultations with the Evaluation Reference Group. A team of competitively selected independent evaluators will conduct the cluster evaluation and prepare the evaluation report and Country/territory case studies.

B. CONTEXT

a. Country/territory Profile

Bosnia and Herzegovina

Bosnia and Herzegovina (BiH) consist of two entities (Federation of Bosnia and Herzegovina (FBiH) and Republika Srpska (RS)), and the Brcko District of Bosnia and Herzegovina (BD). Each of the entities and BD have own governments and parliaments/assemblies while at the state level there is the tripartite Presidency of BiH, the Council of Ministers of BiH and bicameral Parliamentary Assembly of BiH. FBiH is further divided into 10 cantons that have major responsibility for development of economic, health, education and social protection sectors. Finally, entities are divided into municipalities; 79 in FBiH and 68 in RS. In line with the 2013 Census report, the total number of citizens in BiH is 3.531.159[68]. Population growth has a negative trend since 2007, while the fertility rate remains one of the lowest in the world. Population migrations to developed countries are also underway, where mostly young, skilled people dissatisfied with the current socio-political situation leave BiH, causing a major brain drain. Finally, UN estimates BiH will have at least 30% of persons over 65 years of age by mid-century.

The Republic of North Macedonia

Based on population estimates, the country had over 2 million inhabitants in 2017[1]. The population is increasingly aging and the total fertility rate (TFR) is 1.50 live births per woman in the last few years, which is below the replacement rate. The 2002 Census was the last census undertaken in the country and it was evaluated by the international community as well organized. The country was granted EU candidate status since 2005, with accession talk to start 2019, if all agreed political steps with neighboring countries and international community are put in place.

The key issues that population faces regarding SRH is increasing maternal mortality and adolescent pregnancy, rise of STIs especially among young people, and low use of modern contraceptive. The rates are lower among rural, poor and low-educated women and due to the lack of sexuality education, cultural barriers, stigma and discrimination, especially for the Roma and other marginalized groups. The SRH health services lack referral pathways between different level of care as well as shortage of human resources and poor quality of care. The regulatory-administrative system for evidence-based clinical governance is in rudimentary stages.

Gender inequality and reproductive health and rights in the country are still lagging behind compared with the EU countries. Acceptance of domestic violence (DV) is closely associated with a woman's

[68] The 2013 Census Report, although officially recognised by the BiH Agency for Statistics and the FBiH Institute for Statistics, as well as by the members of the International Monitoring Missions (including Eurostat, UNFPA, UNSD and UNECE), has been disputed by the RS Institute for Statistics for the reason of disagreement over the methodology used for data processing. Instead, the RS Institute for Statistics has developed own Census report that is in use in this entity. By the time this ToR is developed, there has been no agreement between government institutions on how this issue will be solved so different administrations are using different census results.

education level. Due to the societal gender social norms, especially vulnerable to gender based violence are members of the young key populations (defined as MSM, sex workers, PWID, PLHIV). Furthermore, these are especially vulnerable to HIV and other STIs. The harmful practice of early marriage, formal and informal, prevents girls from finishing education, acquiring skills and competences to work, thus making them more vulnerable to poverty and social exclusion.

The Republic of Serbia

The Republic of Serbia was granted status of the EU candidate country in 2012, and current reforms and all national policies are marked with the efforts to fulfill conditions for EU accession. Territory of Serbia is divided into regions which do not have any administrative power or legal subjectivity, but are functional territorial units for the purposes of regional planning and policy implementation. Within these regions Serbia is further divided into districts including the City of Belgrade as one district, and within districts into municipalities and cities which are the administrative units of local self-government. According to official estimation there were 7,058,322 inhabitants in 2016[69]. Serbia has been facing unfavorable demographic trends: low natality rate, negative natural growth rate, slow increase in life expectancy, ageing (average age is 42,9) and increase in share of population aged 65 years and over, but also high level of internal migrations from rural to to urban areas and emigration, resulting in overall negative migration balance.

Main challenges in **s**exual and reproductive health are low use of modern contraception, underreported, but still high number of induced abortions, insufficient knowledge of youth about the SRH and related risks, higher incidence and mortality from (preventable) cervical and breast cancers compared to EU. Gender inequalities are still underlined and there are persistent deep-rooted stereotypes and traditional roles of women and men in the family and society. Since 2015, the country have experienced a strong inflow of migrants, refugees and asylum-seekers taking the Balkan route to the Western Europe.

Kosovo

Kosovo is situated in the Western Balkans covering around 11 thousand square kilometers. After conflict cessation in 1999, the United Nation Security Council by its resolution 1244 established the United Nations Interim Administration Mission and the North Atlantic Treaty Organization-led Multinational Force was deployed. On 17 February 2008, the Kosovo Assembly declared independence followed by the establishment by the European Union of the European Union Rule of Law Mission within the framework of the United Nations Security Council Resolution 1244 aiming to support European integration. Kosovo is recognized as an independent country by 114 out of 193 United Nations members and by 23 out of 28 European Union (EU) members. Kosovo is a potential candidate for EU membership, a process that was accelerated with the signing of the Stabilization Association Agreement in October 2015, in force since April 2016. The current Government was voted in on September 9, 2017.

According to the 2011 Census the population is 1.7 million with 60 per cent in rural areas. Northern Kosovo municipalities did not participate in the 2011 census. Total number of households is 300,000 with the average household size of 6 members. One out of every four Kosovars lives abroad and it is estimated that

[69]Statistical Office of Serbia (2017) *Demographic Yearbook 2016,* Belgrade.

http://www.stat.gov.rs/WebSite/public/PublicationView.aspx?pKey=41&pLevel=1&pubType=2&pubKey=4225

over 50,000 migrated illegally in 2015. Around 50 per cent of population is under the age of 25 and only 6 per cent over 65 years. The Total Fertility Rate is approx two children per women and the annual rate of population growth is 0.9 per cent. Life expectancy at birth is 70.2 years, 10 years lower than the European Union.

b. UNFPA Programmes

Bosnia and Herzegovina

The 2nd UNFPA Country Programme Document for Bosnia and Herzegovina (DP/FPA/CPD/BIH/2) has been approved by the UNDP/UNFPA/UNOPS Executive Board at its second regular session in September 2014. The programme initially covered the period from 2015 to 2019, but has been extended at no cost for 1 year through 2020, following the respective extension of the UN Development Assistance Framework (UNDAF) for Bosnia and Herzegovina. The UNFPA financial commitment over 5 years towards the programme was approved at $ 2.4 million from regular resources ($ 0.8 million for sexual and reproductive health and rights component, $ 0.7 million for adolescents and youth component, $ 0.3 million for gender equality and women's empowerment component, $ 0.3 million for population dynamics component, and $ 0.3 million for programme coordination and assistance). UNFPA also committed to mobilize $ 1 million from other resources to co-fund the programme. By mid-2018, UNFPA office in BiH has managed to fundraise over $ 1.2 million, mostly for the gender equality and women's empowerment component.

Sexual and Reproductive Health initiatives have been focusing primarily on development of adequate population health policies that will develop systems aimed at improving the provision of family planning services, improving the reproductive health of general population (with focus on most vulnerable population groups) and providing adequate protection and health support to those affected by emergencies, along with improving the capacities of government stakeholders for the provision of such services in local communities. Youth initiatives have been mostly related to the provision of technical support and development of youth policies, as well as support to development and implementation of Comprehensive Sexuality Education curricula across the country. Specific focus has also been put on the prevention of early marriages among the Roma population. Initiatives related to Gender-based Violence were mostly focused on the prevention of stigma against the survivors of Conflict-related Sexual Violence (CRSV) and development of referral systems for the provision of support to this population group (including building capacities of institutional and religious stakeholders for first contacts with and provision of support to the survivors of CRSV). Finally, Population Dynamics initiatives mostly focus on the provision of evidence for development of population policies in the country, as well as support to development of policies on ageing and promotion of Healthy Ageing Centres.

The Republic of North Macedonia

UNFPA is present in the country since 2007 and the first UNFPA five year Country Program Document (CPD) 2016-2020, developed with the Government and other partners, was approved by the Executive Board in 2015. CPD's main focus is enhancing sexual and reproductive health and rights, and address gender based violence, with focus on youth and improving the use of population information in development policies.

The UNFPA financial commitment over 5 years towards the programme was approved at $ 1.5 million from regular resources ($ 1.1 million for sexual and reproductive health and rights component, $ 0.1

million for adolescents and youth component, $ 0.1 million for population dynamics component, and $ 0.2 million for programme coordination and assistance). UNFPA also committed to mobilize $ 1 million from other resources to co-fund the programme. By mid-2018, UNFPA office has managed to fundraise over $ 0.5 million, mostly for the humanitarian preparedness and response in the period 2015-2016 from internal, UNFPA and donor resources, and, SRH and GBV activities and support to PwD.

UNFPA has well-established strong partnerships with the Government and its bodies, UN Agencies CSOs and academia. In 2018, UNFPA's co-funding Mechanism (Consistent with Executive Board decision (2013/31) is applied in the country for the first time.

UNFPA has built on the existing investments of the regional office in various areas, and supported national Government in drafting Action Plan to SRH Strategy (to be adopted in 2018). The achievements include development of national clinical guidelines adaptation, implementation and audit program, introduction of obstetric surveillance system, and introduction of MISP concept in the national policies. From the nationally born efforts, it's worth highlighting the development of family planning training package, conducting of a number of analysis and assessments, focusing on Market Segmentation Research, Logistics Management Information System, Emergency Obstetrics and Neonatal Care, Cervical and Breast Cancer Screening, Social Marketing, etc. A significant number of professionals were trained based on evidence-based practices in the fields of family planning; MISP; clinical management of rape and for the prevention and management of GBV; clinical guidelines development, adaptation and audit; and obstetrics surveillance. Though gender is not specific Outcome of the CPD it is cross cutting issue in all other outcomes, resulting in significant achievements in humanitarian preparedness and response as well as opening of the first in the Western Balkan region, sexual assault referral centers and raising awareness among you and engagement of men in gender equality efforts. UNFPA is part of the recently approved joint UN Programme on prevention of institutionalization of People with Disabilities (PwD), supported by UNPRPD Disability Fund. Over the next two years, UNFPA will implement SRH and GBV prevention and response activities among PwD in the South Western region of the country, in partnership with the Platform for SRH of persons with disabilities, led by NGO HERA.

UNFPA works through key populations community organizations and since 2017 have partnered with NGO Star Star to support community empowerment of young key populations for their rights and protection.

UNFPA partners with NGO "Macedonian Anti-Poverty Platform" to implement analysis, policy dialogue and advocacy for population data collection and analysis to understand population trends, SDGs implementation and advocacy for full implementation of Madrid Plan of Action for Ageing.

The Republic of Serbia

The work of UNFPA in Serbia started in 2006, guided by UNDAF framework. The first UNFPA five year Country Program Document (CPD) 2016-2020 was developed in 2015, in line with UNDAF (2016-2020) and the UNFPA Strategic Plan 2014-2017. CPD's is concentrated on three areas: 1. Sexual and reproductive health services and rights; 2. Policies and programmes related to adolescents and youth and 3. Evidence based policies addressing population dynamics. Activities envisaged in CPD are being implemented through cooperation with all relevant governmental institutions, academia experts associations, UN Agencies and CSOs.

In the field of SRH, UNFPA CO supported the Ministry of Health in policy development and capacity building. The first National Program for Sexual and Reproductive Health and Rights was adopted at the end of 2017. In addition, CO supported development of the National Clinical Guidance for Modern Contraceptive Provision, and Procedure for SRH in emergency situation, based on MISP. Number of health professionals was trained on MISP, GBV and clinical guidelines development.

As part of humanitarian response, UNFPA CO Serbia provided the access to SRH service to the women and girls within migration population. UNFPA CO supported Ministry of Labour, Employment, Veteran and Social Affairs to develop Standard Operating Procedures of the Republic of Serbia for Prevention and Protection of Refugees and Migrants from Gender Based Violence and organized several trainings on this topic. UNFPA CO Serbia recognised vulnerability of boys and young men and supported BOYS on the MOVE life skills programme.

In the field of youth programs and policies, UNFPA CO is working on raising awareness on the importance of sexuality education in schools. CO also works with men and boys on abandoning harmful gender stereotypes, through trainings, public actions and campaigns. CO supported implementation of the International Men and Gender Equality Survey (IMAGES), the most comprehensive survey on men's attitudes and practices related to gender equality. CO supported Ministry of Youth and Sports to review youth policy and work of youth organisations and to define recommendation to align goals of National Youth Strategy 2015 – 2025 with realisation of SDGs.
In the field of rights-based policies that integrate evidence on emerging population issues, UNFPA CO is supporting several researches related to: status and needs of the elderly households in rural and urban areas, ways of balancing the work and parenting in Serbia, and demographic situation in several selected municipalities. Researches provide evidences for integrating issues related to population dynamics in national policies and programmes and elaborating targeted strategies and interventions to address the challenges identified.

Kosovo

Currently, UNFPA Kosovo is implementing its first Draft programming document for Kosovo developed in a participatory approach with partners, and approved by Executive Board in 2015. The UNFPA financial commitment over 5 years towards the programme was approved at $ 1.5 million from regular resources ($ 0.6 million for sexual and reproductive health and rights component, $ 0.4 million for adolescents and youth component, $ 0.3 million for population dynamics component, and $ 0.2 million for programme coordination and assistance). UNFPA also committed to mobilize $ 1 million from other resources to co-fund the programme.

The programme is based on Kosovo emerging priorities on governance and rule of law and on human capital and social cohesion and it seeks to support Kosovo efforts to: (a) develop integrated and high-quality sexual and reproductive health services that are affordable, accessible, and meet human rights standards; (b) empower youth and women, with particular emphasis on marginalized groups such rural and Roma, Ashkali and Egyptian; (c) Promote gender equality and address gender-based violence and harmful practices; (d) support to development of evidence-based population policies.

The Sexual And reproductive Health initiatives will focus on advocacy and policy dialogue, knowledge management, and capacity building for strengthening evidence-based health policy-making and planning; improving capacity of health personnel to deliver quality family planning, sexually

transmitted infections, HIV and AIDS, adolescent friendly sexual and reproductive health services, cervical screening and response to gender based violence; strengthening reproductive health commodity security, including social marketing of male condoms; improving the population knowledge on sexual and reproductive health issues with the special focus on marginalized groups; strengthen institutional and civil society initiatives in addressing gender based violence, conflict related sexual violence, and gender-biased sex selection; integrating Minimum Initial Service Package for reproductive health in the emergency preparedness plans.

Adolescent and youth initiatives will focus on advocacy, policy advice and technical support for: improve availability and utilization of data for development evidence based, gender-sensitive sexual and reproductive health and rights-related policies and strategies on youth, with focus on marginalized groups, including the Roma, migrants and key populations at risk of HIV and sexually transmitted infections; revision of school curricula to incorporate comprehensive sexuality education that meet international standards, including human rights and gender equality;strengthening youth peer education programming and utilize new technologies to promote sexual and reproductive health and rights, including gender transformative programming. Population dynamics initiatives will focus on advocacy and policy dialog, technical assistance and capacity building in support evidence-based decision making at the central and municipal levels through: strengthen national capacities for population data collection, analysis, dissemination and use; support Kosovo authorities, independent human rights organisations, and civil society networks to use comprehensive methodologies for monitoring, analysing and reporting;partnerships for the development of comprehensive rights-based and evidence-based population policies to address emerging population trends, population dynamics, gender and youth;

THE OBJECTIVES AND SCOPE OF THE CLUSTER EVALUATION

The overall objectives of a cluster evaluation: (i) an enhanced accountability of UNFPA and its offices for the relevance and performance of their programmes and (ii) a broadened evidence-base for the design of the next programming cycle.

The specific objectives:

- To provide an independent assessment of the progress of each programme towards the expected outputs and outcomes set forth in the results framework of the respective programmes;
- To provide an assessment of each offices positioning within the developing community and national partners, in view of its ability to respond to national priority needs while adding value to the development results.
- To draw key lessons from past and current cooperation and provide a set of clear, specific and action-oriented strategic recommendations for the next programming cycle.

The evaluation (including country/territory case studies) will cover all activities planned and/or implemented during the period: Bosnia and Herzegovina 2013-2018, The Republic of North Macedonia 2010-2018, The Republic of Serbia 2010-2018, and Kosovo 2010-2018 within each programme: sexual and reproductive health and rights, adolescent and youth, population dynamics, gender equality and humanitarian response, and cross-cutting areas: partnership, resource mobilization, and communication).

The scope of the evaluation is extended beyond the current programme period is assess achievement/non-achivement of higher level development results. Besides the assessment of the intended effects of the programme, the evaluation also aims at identifying potential unintended effects. The cluster evaluation should analyze the achievements of UNFPA against expected results at the output and outcome levels, its compliance with the UNFPA Strategic Plans for 2014-2017 and 2018--2021, the UN partnership Framework, and national development priorities and needs.

The evaluation will reconstruct the programme intervention logic and assess the extent to which the ongoing programmes have chosen the best possible modalities for achieving the planned results in the current development context. The evaluation will examine the programmes for such critical features as relevance, effectiveness, efficiency, sustainability, UN coordination, and added value. The evaluation will apply appropriate methodology including UNEG Handbook for Conducting Evaluations of Normative Work in the UN System70 for assessing the equity and vulnerability, gender equality71, human rights in development and humanitarian programme[72.]

Based on the conclusions and recommendations of the cluster evaluation, the UNFPA offices will prepare a formal management response to ensure that all evaluation recommendations are considered and/or acted upon.

C. EVALUATION CRITERIA AND EVALUAITON QUESTIONS

In accordance with the methodology for CPEs as set out in the UNFPA Handbook "How to Design and Conduct a Country Programme Evaluation" (2012), the evaluation will be based on finding answers to a number of questions covering the following evaluation criteria:

Relevance:

- To what extent is the UNFPA programme (i) adapted to the needs of women, adolescents and youth, people at risk of HIV infections, disabled and elderly persons, (ii) and in line with the priorities set by the international and national policy frameworks, iii. aligned with the UNFPA policies and strategies and the UN-Ukraine Partnership Framework, as well as with interventions of other development partners? Do planned interventions adequately reflect the goals stated in the UNFPA Strategic Plan?
- To what extent has the offices been able to respond to changes in the national development context and, in particular, to the aggravated humanitarian situation in countries/territory?

Effectiveness:

- To what extent have the intended programme outputs been achieved? To what extent did the outputs contribute to the achievement of the planned outcomes (i. increased utilization of integrated SRH Services by those furthest behind, ii. increased the access of young people to quality SRH services and sexuality education, iii. mainstreaming of provisions to advance

70 UNEG Handbook for Conducting Evaluations of Normative Work in the UN System, http://www.uneval.org/document/detail/1484

71 Integrating Human Rights and Gender Equality in Evaluations, UNEG, http://www.uneval.org/document/detail/1616

72 Equity focused evaluation: https://mymande.org/sites/default/files/EWP5_Equity_focused_evaluations.pdf

gender equality, and iv. developing of evidence-based national population policies) and what was the degree of achievement of the outcomes?

- To what extent has UNFPA contributed to an improved emergency preparedness in BiH, The Republic of North Macedonia, the Republic of Serbia, and Kosovo, and in the area of maternal health / sexual and reproductive health including MISP?
- To what extent has each office been able to respond to emergency situation in its AoR, if one was declared? What was the quality and timeliness of the responses?

Efficiency:

- To what extent has UNFPA made good use of its human, financial and technical resources, and has used an appropriate combination of tools and approaches to pursue the achievement of the results defined in the UNFPA programme documents?

Sustainability:

- Are programme results sustainable in short and long-term perspectives?
- To what extent have the partnerships established by UNFPA promoted the national ownership and sustainability of supported interventions, programmes and policies?

UNCT Coordination:

- To what extent did UNFPA contribute to coordination mechanisms in the UN system at country/territory level?
- To what extent does the UN Partnership Framework reflect the interests, priorities and mandate of UNFPA?
- To what extent did UNFPA contribute to ensuring programme complementarity, seeking synergies and avoiding overlaps and duplication of activities among development partners working in countries/territory?

Added value:

- What is the main UNFPA added value in the area context as perceived by UNCT, government and civil society organiations?

D. METHODOLOGY AND APPROACH

The cluster evaluation approach and methodology will include desk review, data collection and analysis methods.

Data Collection

The evaluation will use a multiple-method approach to data collection, including documentary review, group and individual interviews, focus groups and field visits to programme sites as appropriate. The collection of evaluation data will be carried out through a variety of techniques ranging from direct observation to informal and semi-structured interviews and focus/reference groups discussions. The evaluators will be required to take into account ethical considerations when collecting information.

Retrospective and Prospective Analysis

Evaluators may assess the extent to which programme results effects have been already achieved, but also look into the prospects, i.e. the likelihood of results being achieved. Evaluators are expected to conduct retrospective assessments for the most part, analysing *what* has happened and the reasons *why,* but prospective assessments are also an option to determine results of ongoing programme. However, whenever evaluators choose to conduct prospective assessments they should explicitly indicate it in the methodological chapters of the design and final reports. Evaluators should also explain the reason why a prospective assessment has been chosen.

Validation mechanisms

The evaluators will use a variety of methods to ensure the validity of the data collected. Besides a systematic triangulation of data sources and data collection methods and tools, the validation of data will be sought through regular exchanges with the UNFPA programme staff and the Evaluation Reference Group. Counterfactual analysis is to be applied wherever possible to explore the cause-to-effect relationships within the programme being evaluated.

Stakeholders participation

The evaluation will adopt an inclusive approach, involving a broad range of partners and stakeholders. The Evaluation Manager in each office will perform a stakeholders mapping in order to identify both UNFPA direct and indirect partners (i.e., partners who do not work directly with UNFPA and yet play a key role in a relevant outcome or thematic area in the national context). These stakeholders may include representatives from the government, civil-society organizations, the private-sector, UN organizations, other multilateral organizations, bilateral donors, and most importantly, the beneficiaries of the programme.

An Evaluation Reference Group (ERG) will be established by the UNFPA Office in each country/territory comprising key programme stakeholders (national governmental and non-governmental counterparts, Evaluation Manager from the UNFPA Office). The ERG will review and provide inputs to the country/territory case study, provide feedback to the evaluation design report, facilitate access of evaluators to information sources, and provide comments on the main deliverables of the evaluation, in particular the country/territory case studies at the draft stage.

E. EVALUATION PROCESS

The evaluation will unfold in five phases, each of them including several steps.

1) Preparation

This phase, managed by the UNFPA Offices, will include:

- Drafting of cluster programme evaluation (CPE) terms of reference (ToR);

- Establishing an Evaluation Reference Group (ERG);
- Receiving approval of the CPE ToR from the UNFPA Regional Office;
- Selecting potential evaluators;
- Receiving pre-qualification of potential evaluators from the UNFPA Regional Office;
- Recruiting evaluators and establishing an Evaluation Team chaired by the Evaluation Team Leader;
- Preparing the initial set of documentation for the evaluation, including the list of Atlas projects and stakeholder map.

The preparation phase may include a short scoping mission to the UNFPA Office in Bosnia and Herzegovina located in Sarajevo by the Evaluation Team Leader to gain better understanding of the development context, UNFPA programme and partners, refine the evaluation scope, etc.

2) Design phase

This phase will include:

- a documentary review of all relevant documents available at UNFPA HQ and CO levels regarding the programmes for the period being examined. For the evaluation of programmes in The Republic of North Macedonia, Kosovo and Serbia prior to their first approved Programme, other evaluative evidence documents for the period from 2014 will be reviewed;
- a stakeholder mapping – The evaluation managers will prepare a mapping of stakeholders relevant to the evaluation. The mapping exercise will include institutional and civil-society stakeholders and will indicate the relationships between different sets of stakeholders;
- an analysis of the intervention logic of the programme, - i.e., the theory of change meant to lead from planned activities to the intended results of the programme;
- the finalization of the list of evaluation questions and development of evaluation matrix for each office;
- the development of a data collection and analysis strategy as well as a concrete work plan for the field phase.

At the end of the design phase, the evaluation team leader will produce an evaluation design report summarizing the results of the above-listed steps and tasks. This report must demonstrate how the evaluators have understood the purpose and objectives of the CPE, its scope and criteria, the country/territory's development context and programme intervention logic, selected evaluation questions, and should convincingly illustrate how the evaluators intend to carry out the evaluation and ensure its quality.

The design report must include the evaluation matrix, stakeholders map, final evaluation questions and indicators, evaluation methods to be used, information sources, approach to and tools for data collection and analysis, calendar work plan, including selection of field sites to be visited – prepared in accordance with the UNFPA Handbook "How to Design and Conduct a Country Programme Evaluation". The design report should also present the reconstructed programme intervention cause-and-effect logic linking actual needs, inputs, activities, outputs and outcomes of the programme. The design report needs to be

reviewed, validated and approved by the UNFPA Evaluation Steering Committee before the evaluation field phase commences.

The evaluation team leader will facilitate a training on evaluation methodology, evaluation tools, data collection, data analysis, and preparation of country/territory case studies for national evaluators hired by UNFPA. The national evaluators will finalize country/territory stakeholders map, adjust/translate data collection tools etc.

3) **Field phase**

After the design phase, the National Evaluation Team will undertake a two-week collection and analysis of the data required in order to answer the evaluation questions consolidated at the design phase, and to analyze the findings with a view to formulate the preliminary conclusions and recommendations of the country/territory case study. At the end of the field phase, the country/territory Evaluation Team and Evaluation Team Leader will provide the UNFPA office with a debriefing presentation on the preliminary results of the country/territory case study, with a view to validating these preliminary findings and testing tentative conclusions and/or recommendations.

At the end of the field phase, Evaluation Team Leader will provide the Evaluation Steering Committee with a debriefing presentation on the preliminary results of the evaluation (online or in person), with a view to validating preliminary findings and testing tentative conclusions and/or recommendations.

4) **Synthesis phase**

During this phase, the Evaluation Team will continue the analytical work initiated during the field phase and prepare a **first draft evaluation report and country/territory case studies**, taking into account comments made by the Evaluation Steering Committee at the debriefing meeting.

This **first draft country/territory case studies** will be submitted to each Evaluation Reference Group for comments (in writing). Comments made by the Evaluation Reference Group and consolidated by the evaluation managers will then allow the Evaluation Team to prepare a **second draft evaluation report and country/territory case studies**. This second draft evaluation report will form the basis for individual office **dissemination seminar(s)**, which should be attended by all the key programme stakeholders in the office AoR. The **final evaluation report** will be drafted shortly after the seminar(s), taking into account comments made by the participants.

5) Dissemination and follow-up

During this phase, UNFPA offices, including relevant divisions at UNFPA headquarters, will be informed of the evaluation results. The evaluation report, accompanied by a document listing all recommendations, will be communicated to all relevant units within UNFPA, with an invitation to submit their response. Once completed, this document will become the *management response* to the evaluation. The UNFPA offices will provide the management response within six weeks of the receipt of the final evaluation report.

The evaluation report, along with the CPE ToR and management response, will be published in the UNFPA evaluation database within eight weeks since their finalization. The evaluation report will also be made available to the UNFPA Executive Board and will be widely distributed within and outside the organization.

F. EXPECTED OUTPUTS/ DELIVERABLES

The evaluation team will produce the following deliverables:

- a cluster evaluation design report including (as a minimum): a) a stakeholder map ; b) the evaluation matrix (including the final list of evaluation questions and indicators) ; c) the overall evaluation design and methodology, with a detailed description of the data collection plan for the field phase. The design report should have a maximum of 70 pages;
- a first draft cluster evaluation report and four first draft country/territory studies accompanied by a debriefing PowerPoint presentation synthesizing the main preliminary findings, conclusions and recommendations of the evaluation, to be presented and discussed with the Evaluation Steering Committee during the (online or in person) debriefing meeting foreseen at the end of the field phase;
- a second draft cluster evaluation report and four country/territory case studies (followed by a second draft, taking into account potential comments from the Evaluation Steering Committee) and . The evaluation report should have a maximum of 50 pages (plus up to 70 pages for each Case Study, and plus annexes); four PowerPoint presentations of the results of the evaluation for the dissemination seminars to be held separately in each office AoR, and led by the national evaluators;
- a final evaluation report including four country/territory case studies, based on comments expressed during the dissemination seminars.

All deliverables will be written in English. The PowerPoint presentation for the dissemination seminars and the final evaluation report might need to be translated in local languages if requested by national counterparts.

Work plan/ Indicative timeframe

Phases/Deliverables	Dates
1. Drafting and approval of the ToRs - *Evaluation ToR* - *ToR for the Evaluation Steering Committee* - *TOR for international evaluator* - *TORs for local evaluators, experts and assistants* - *TOR for the Evaluation Reference Group(s)*	July 2018
2. Recruitment/vetting of international and national experts	August - October 2018
3. Training workshop for national evaluators (5 days)	4th week of October 2018

4. Design phase: - *Submission of the design report*	August - October 2018 *4th week of October 2018*
5. Field phase - *Bosnia and Herzegovina* - *Kosovo* - The Republic of North Macedonia - *Serbia*	November 2018 - February 2019 *November - December 2018* *December 2018 - January 2019* *January - February 2019* *January - February 2019*
6. Synthesis phase (evaluation report + case studies): - *1st draft case study for Bosnia and Herzegovina and presentation to Steering Committee* - *1st draft case study for Kosovo and presentation to Steering Committee* - *1st draft case study for The Republic of North Macedonia and Serbia, and presentation to Steering Committee* - *2nd draft case studies (for all 4 COs)* - *Draft cluster evaluation report* - *Dissemination seminars (in all four COs)* - *Final evaluation report and all four case studies (BiH,* The Republic of North Macedonia*, Serbia, Kosovo)*	January - mid-June 2019 *Mid-January 2019* *Mid-February 2019* *End of March 2019* *3 weeks from presentation of 1st drafts* *1st week of May 2019* *March - May 2019* *Mid-June 2019*

G. COMPOSITION AND QUALIFICATION OF THE EVALUATION TEAM

The evaluation team will consist of:

a) **A Team Leader** with overall responsibility for development of cluster design report, facilitation of a training on evaluation design, field data collection, data analysis and submission of country/territory case studies. Furthermore, s/he will lead and coordinate the work of the National Evaluation Team in the field phase and will be responsible for drafting of case studies together with national evaluators, as well as the quality assurance of all evaluation deliverables. Finally, s/he will be responsible for writing draft/final evaluation report. S/he will be in regular contact with the Evaluation Team remotely via

Internet to get updates on the field work progress. In case s/he decides that the collected information is not sufficient or of good quality, s/he may request national evaluators to conduct additional interviews with key stakeholders or, as a last resort, s/he may travel to the country/territory for preparing the draft country/territory case studies. The Evaluation Team Leader should have the following qualifications:

- Advanced degree in social sciences, political sciences, economics or related fields;
- Minimum 7 years of experience of complex evaluations in the field of development aid for UN agencies and/or other international organizations in the position of lead evaluator,
- Specialization in one of the programmatic areas covered by the evaluation (reproductive health and rights, gender equality, population and development, adolescent and youth policies)
- Demonstrated ability and knowledge to collect and analyze qualitative and quantitative data (a training on data analysis using software e.g. SPSS);
- Good knowledge and experience of programme evaluation in the humanitarian settings will be strong assets
- Knowledge of demographic, political, social and economic conditions in the Western Balkans (preferable);
- Familiarity with UNFPA or UN programming;
- Excellent writing and communication skills;
- Excellent command of both spoken and written English is required.

b) **Four national evaluators** (one in each office) with overall responsibility for coordinating field data collection, data analysis, drafting of Country/territory Case studies with the Team Leader, and providing support to the Team Leader with drafting cluster evaluation report in addition to collecting data for one substantive component. Each national evaluator should have expertise in at least one of the core subject area/s of the evaluation - Sexual and Reproductive Health, Gender-based Violence or Population Dynamics. National evaluators will also facilitate evaluation dissemination seminars and will assist the Team Leader in embedding comments from these seminars into the Case Studies and joint evaluation report. Besides personal expertise in conducting complex programme evaluations, the evaluators should have a good knowledge of the national development context and be fluent in the local language and English.

- Advanced degree in social sciences, medicine, public health, women's studies, gender equality, population studies, demography, statistics or related fields;
- At least 5 years of experience in conducting evaluations as a member of evaluation team or individual evaluator for UN agencies and/or other international organizations;
- Demonstrated ability and knowledge to collect qualitative and quantitative data;
- Knowledge of demographic, political, social and economic conditions in the area in which the evaluation will be conducted;
- Familiarity with UNFPA or UN programming;
- Excellent writing and communication skills;
- Fluency in local and English Language.

c) **National experts** (two or more in each office), who will each provide expertise in one

programmatic area of the evaluation The expert will take part in the data collection and analysis work, and will provide substantive inputs into the evaluation processes through participation at methodology development, meetings, interviews, analysis of documents, briefs, comments, as advised and led by the National Evaluator and Evaluation Team Leader. The modality and participation of experts in the evaluation process, including participation in interviews/meetings, provision of technical inputs and reviews of the design report, drafting parts of the evaluation reports, will be agreed by the Evaluation Team Leader and done under her/his supervision and guidance. The necessary qualifications of the evaluators will include:

- Advanced degree in social sciences, medicine, public health, women's studies, gender equality, population studies, demography, statistics or related fields;
- At least 5 years of experience in implementing initiatives in at least one of the core subject area/s of the evaluation - Sexual and Reproductive Health, Gender-based Violence or Population Dynamics;
- Demonstrated ability and knowledge to collect qualitative and quantitative data;
- Knowledge of demographic, political, social and economic conditions in the area in which the evaluation will be conducted;
- Familiarity with UNFPA or UN programming;
- Excellent writing and communication skills;
- Fluency in local and English Language.

d) **Four research assistants** (one in each cluster office) that will collect, compile and analyze available data relating to four cluster countries/territory in a form of the database. They will also be responsible for contacting relevant evaluation stakeholders and arranging field work for national evaluators, and logistical support for preparation of dissemination seminars. Besides personal expertise in conducting researches, the assistants should have a good knowledge of the national development context and be fluent in the local language and English. Research assistants will be supported and supervised by evaluation managers in each office.

- Bachelor's degree in statistics, social sciences, population studies, economics or related fields;
- Minimum 2 years of experience in data collection and analysis (with the use of the relevant statistical software packages);
- Knowledge of qualitative/quantitative research methods;
- Familiarity with UNFPA or UN operations;
- Fluency in written and spoken English

The Evaluation Team will conduct the evaluation in accordance to the "Handbook on How to Design and Conduct a Country Programme Evaluation at UNFPA" and their work 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 evaluators will be requested to sign the Code of Conduct prior to engaging in the evaluation exercise.

Remuneration and duration of contract

Repartition of work days among the Evaluation Team will be the following:

- For the Team Leader: a total of 60 work days – 12 work days for development of design report, 6 work days for preparation and facilitation of a training workshop for National Evaluators, 32 work days for joint development of four Case Studies with National Evaluators and off-site technical support to national evaluators if needed, and 10 work days for development of draft and final evaluation reports;
- For National Evaluators: a total of 32 work days each - 7 work days for participation at the training workshop, 15 work days for field work, and 10 days for development and presentation of draft and final Case Study report);
- For National Experts: a total of 27 work days each - 7 work days for participation at the training workshop, 15 work days for field work, and 5 work days for preparing draft and final Case Study.
- For Research Assistants: a total of 34 work days each - 10 days for reviewing and analysing data, 5 work days for preparation of field phase, 14 days for support during the field phase, and 5 work days for support to organisation of dissemination seminars.

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

Team Leader:

- Upon satisfactory submission of evaluation design report and facilitation of the training: 40%
- Upon satisfactory development of first draft Case Studies: 20%
- Upon satisfactory finalisation of the final evaluation report and Case Studies: 40%

National Evaluators:

- Upon satisfactory completion of the evaluation workshop and support to development of the design report: 30%
- Upon satisfactory implementation of the field phase, and development of first draft Case Studies: 30%
- Upon satisfactory facilitation of dissemination seminar and finalisation of the joint evaluation report with Case Studies: 40%

National Experts:

- Upon satisfactory implementation of the field phase and contribution to development of first draft Case Studies: 50%
- Upon satisfactory participation at the dissemination seminar and contribution to development of the final evaluation report with Case Studies: 50%

Research Assistants:

- Upon satisfactory review and analysis of data: 50%
- Upon satisfactory preparation and execution of the dissemination seminar: 50%

Daily Subsistence Allowance (DSA) will be paid per nights spent at the place of the mission following UNFPA DSA standard rates. Travel costs will be settled separately from the consultant fees. DSAs and travel costs of the Team Leader will be shared among the four cluster offices.

H. MANAGEMENT AND CONDUCT OF THE EVALUATION

The evaluation will be guided by these terms of reference approved by the UNFPA Regional Office on behalf of UNFPA Evaluation Office, and the UNFPA Handbook "How to Design and Conduct a Country Programme Evaluation". The evaluation and country/territory case studies will be conducted by an independent Evaluation Team whose members are pre-qualified by the UNFPA Regional Office, but will be managed by the UNFPA Office.

The Evaluation Steering Group:

Cluster Evaluation Steering Committee (CESC) will have overall responsibility of evaluation design, implementation and dissemination of the evaluation results. The Evaluation Steering Committee will have overall supervision on the Cluster Evaluation Team (including International Team Leader and National Teams) and evaluation processes. CESC will be comprised of UNFPA Representative for the Balkans Cluster, four Assistant Representatives, CO M&E Programme Analyst and RO M&E Advisor.

The role of the CESC will include the following tasks, but not limited to:

- Develop and agree ToR for the evaluation along with ToR for Reference Group(s) and ToRs for all Evaluation Team members (International Team Leader, National Evaluators, National Experts and National Research Assistants);
- Act as first point of contact to the Evaluation Team;
- Develop initial list of stakeholders for interviews and propose documentation for review;
- Review and approve draft design report;
- Review and approve draft evaluation report (including preliminary findings, conclusions and recommendations) and Case Studies;
- Liaise with the Evaluation Reference Groups for any issues related to cluster evaluation;
- Provide management response to the final evaluation report;
- Review and approve the final evaluation report and Case Studies;
- Disseminate the final evaluation report to relevant stakeholders in each country/territory.

The Evaluation Manager in each office will:

- Conduct initial stakeholder mapping and develop an Atlas project list for his/her office;
- Develop invitation and contact relevant local stakeholders for participation in the Evaluation Reference Group;
- Support the Evaluation Team in designing the evaluation;
- Provide ongoing feedback for quality assurance during the preparation of the design report and draft and final evaluation report with Case Studies;

- Provide research assistant with available internal and external data relevant to the programme evaluation;
- Liaise with the RO M&E adviser aimed to sharing evaluation updates or requesting evaluation assistance.

The Evaluation Reference Group(s) will be established at the level of each office and composed of representatives from the UNFPA office and relevant programme counterparts.

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

- Provide the Evaluation Team with relevant information and documentation on the programme in their field of expertise;
- Facilitate the access of the National Evaluators to key informants during the field phase;
- Discuss the reports produced by the Evaluation Team, including the design report and draft and final evaluation reports with Case Studies;
- Advise on the quality of the work done by the Evaluation Team.

Bibliography and resources

For Bosnia and Herzegovina:
https://drive.google.com/drive/folders/1tUsvjWl9OwKH5GM7Q1N2BNVh_v4k1qs_?usp=sharing

For Republic of North Macedonia: https://drive.google.com/drive/folders/1wEzxbaK3BDXwL-WVF2bd-XooNpIFjgQv?usp=sharing

For Kosovo:
https://drive.google.com/drive/folders/1CoYBKpCNKP8yBeb_d6ZcofvVNYjJwEip?usp=sharing

For Serbia:
https://drive.google.com/drive/folders/1z7Per3XP8x3KQm6E4gtpQ7dkSEz1SGaC?usp=sharing

Annexes

Annex - Ethical Code of Conduct for UNEG/UNFPA Evaluations

Evaluations of UNFPA-supported activities need to be independent, impartial and rigorous. Each evaluation should clearly contribute to learning and accountability. Hence evaluators must have personal and professional integrity and be guided by propriety in the conduct of their business. In particular:

1. To avoid **conflict of interest** and undue pressure, evaluators need to be **independent,** implying that members of an evaluation team must not have been directly responsible for the policy- setting/programming, design, or overall management of the subject of evaluation, nor expect to be in the near future. Evaluators must have no vested interests and have the full freedom to conduct impartially their evaluative work, without potential negative effects on their career development. They must be able to express their opinion in a free manner.
2. Evaluators should protect the anonymity and **confidentiality of individual informants**. They should provide maximum notice, minimize demands on time, and respect people's right not to engage. Evaluators must respect people's right to provide information in confidence, and must ensure that sensitive information cannot be traced to its source. Evaluators are **not expected to evaluate individuals**, and must balance an evaluation of management functions with this general principle.
3. Evaluations sometimes uncover suspicion of wrongdoing. Such cases must be reported discreetly to the appropriate investigative body.
4. Evaluators should be **sensitive to beliefs, manners and customs** and act with integrity and honesty in their relations with all stakeholders. In line with the UN Universal Declaration of Human Rights, evaluators must be sensitive to and **address issues of discrimination and gender equality**. They should avoid offending the dignity and self-respect of those persons with whom they come in contact in the course of the evaluation. Knowing that evaluation might negatively affect the interests of some stakeholders, evaluators should conduct the evaluation and communicate its purpose and results in a way that clearly respects the stakeholders' dignity and self-worth.
5. Evaluators are responsible for the clear, accurate and fair written and/or oral presentation of study limitations, evidence based findings, conclusions and recommendations.

For details on the ethics and independence in evaluation, please see UNEG Ethical Guidelines and Norms for Evaluation in the UN System
http://www.unevaluation.org/search/index.jsp?q=UNEG+Ethical+Guidelines
http://www.unevaluation.org/papersandpubs/documentdetail.jsp?doc_id=21

[Please date, sign and write "Read and approved"]

UNFPA Cluster CPE Design Report Evaluation Matrix (Draft 0.5) 19 December 2018 Draft – For Internal Review

COMPONENT 1: ANALYSIS BY FOUR FOCUS AREAS (Reproductive Health and Rights (RHR), Youth, Gender Equality (GE), Population and Development (PD)			
RELEVANCE (APPLIES TO ALL FOCUS AREAS)			
EQ1. To what extent is the UNFPA programme (i) adapted to the needs of women, adolescents and youth, people at risk of HIV infections, disabled and older persons, and Roma, (ii) and in line with the priorities set by the international and national policy frameworks, (iii) aligned with the UNFPA policies and strategies and the UNDAF (or equivalent document) as well as with interventions of other development partners? Do planned interventions adequately reflect the goals stated in the UNFPA Strategic Plan?			
EQ1.A To what extent is the UNFPA programme adapted to the needs of women, adolescents and youth, people at risk of HIV infections, disabled, older persons and Roma?			
Assumption to be assessed	**Indicator/Criteria**	**Source of information**	**Method and tools for data collection**
EQ1.A Assumption 1: The evolving needs of women, adolescents and youth, people at risk of HIV infections, disabled and older person and Roma, were taken into account in programme design (both CPD and Annual Planning) and implementation (e.g. targeting/selection of beneficiaries).	1. Evidence of thorough needs assessments, studies, and secondary data analysis used in CP design. 2. The choice of target groups for UNFPA supported interventions is consistent with identified and evolving needs of marginalized populations. 3. Training designs have a focus on marginalized populations.	1.1 UNFPA needs assessment documents 1.2 UNCT common country assessment (CCA) 1.3 Available survey report e.g. Census, DHS, MICS etc. 1.4 UNFPA, UNCT and IP staff 2.1. Country Programme Document (CPD) 2.2. UNFPA Annual Plan 2.3. UNFPA and IP work plan and agreement 2.4. UNFPA and IP staff 3.1 UNFPA training reports 3.2 UNFPA and IP workplans 3.3 Staff interviews	1.1 Document review 1.2 Staff interviews 2.1 Document review 2.2 UNFPA and IP staff interview 3.1 Document review 3.2 Staff interview 3.3 Beneficiary interview
EQ1.A Assumption 1: Findings including analysis for all pertinent program areas: 1. Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD.			
EQ1.B To what extent is the UNFPA programme in line with the priorities set by the international and national policy frameworks?			
Assumption to be assessed	**Indicator/Criteria**	**Source of information**	**Method and tools for data collection**
EQ1.B Assumption 1: The evolving priorities set by the international and national policy frameworks were taken into account in UNFPA programme design (both CPD and	1. Correlation of UNFPA program priorities with priorities set by UNFPA Strategic Plan and national policy frameworks.	1.1 UNFPA programme documents 1.2 UNFPA Strategic Plan and national policy frameworks. 1.3 UNFPA and IP staff	1.1 Document review 1.2 Staff interviews

Annual Planning) and implementation (e.g. targeting/selection of beneficiaries)			
EQ1.B Assumption 1: Findings including analysis for all pertinent program areas: 1. Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD.			
EQ1.C To what extent is the UNFPA programme aligned with the UNFPA policies and strategies and the UNDAF (or equivalent document) as well as with interventions of other development partners?			
Assumption to be assessed	**Indicator/Criteria**	**Source of information**	**Method and tools for data collection**
EQ1.C Assumption 1: There is evidence of alignment between the UNFPA programme and a) UNFPA policies and strategies, b) the UNDAF (or equivalent document) and c) interventions of other development partners.	1. The objectives and strategies of the CP and the AWPs are in line with the goals and priorities set in the UNDAF or equivalent document 2. ICPD goals are reflected in the CP and component activities 3. The CP sets out relevant goals, objectives and activities to develop national capacities 4. Evidence of mainstreaming South-South cooperation in the country programme 5. Evidence of mainstreaming gender equality and women's empowerment 6. Evidence of human rights approach applied in programme design and implementation	1.1 UNFPA programme documents (CPD, AWP, COAR etc.) 1.2 UNFPA Strategic Plan and Annexes 1.3 UNDAF (or equivalent document), interventions of other development partners. 1.4 UNFPA, UNCT and IP staff	1.1 Document review 1.2 Staff interviews
EQ1.C Assumption 1: Findings including analysis for all pertinent program areas: 1. Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD.			
EQ1.D Do planned interventions adequately reflect the goals stated in the UNFPA Strategic Plan?			
Assumption to be assessed	**Indicator/Criteria**	**Source of information**	**Method and tools for data collection**
EQ1.D Assumption 1: The planned interventions adequately reflect the goals of the UNFPA Strategic Plan	1. The objectives and strategies of the CP and the AWPs are in line with the	1.1 UNFPA programme documents (CPD, AWP, COAR etc.) 1.2 UNFPA Strategic Plan and Annexes	1.1 Document review 1.2 Staff interviews

	goals and priorities set in the UNFPA Strategic Plan and Annexes.	1.3 UNFPA, staff	
EQ1.D Assumption 1: Findings including analysis for all pertinent program areas: 1. Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD.			
EQ2. To what extent has the country office been able to respond to changes in the national development context and, in particular, to the aggravated humanitarian situation in countries?			
EQ2.A To what extent has the country office been able to respond to changes in the national development context?			
Assumption to be assessed	**Indicator/Criteria**	**Source of information**	**Method and tools for data collection**
EQ2.A Assumption 1: The UNFPA country office has a mechanism in place to facilitate responses to changes in the national development context.	1. Evidence of a UNFPA mechanism to facilitate a response to changes in national development context.	1. UNFPA country program documents. 2. UNFPA and IP staff	1. Document review 2. Staff interviews.
EQ2.A Assumption 1: Findings including analysis for all pertinent program areas: 1. Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD.			
EQ2.B To what extent has the country office been able to respond to an aggravated humanitarian situation in countries, if such situation has existed?			
Assumption to be assessed	**Indicator/Criteria**	**Source of information**	**Method and tools for data collection**
EQ2.B Assumption 1: UNFPA has provided a timely, appropriate and sufficient response to an aggravated humanitarian situation.	1. Evidence of UNFPA response to an aggravated humanitarian situation.	1.UNFPA country program documents (including annual work plans and annual reports). 2. UN and Government ministry documents. 3. UNFPA, IP and government staff	1. Document review 2. Staff interviews
EQ2.B Assumption 1: Findings including analysis for all pertinent program areas: 1. Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD.			
Assumption to be assessed	**Indicator/Criteria**	**Source of information**	**Method and tools for data collection**
EQ2.B Assumption 2: The current UNFPA CP reflects and is effectively aligned with these key policy/strategy areas: UNFPA Strategic Plan and strategies, goals of ICPD PoA, and the SDGs. [NB: The SDGs were not adopted at the time of CPD drafting and approval. There is room in the country level strategic documents to respond to changes over time, and to react to emergencies. Two issues: a) respond to	1. Degree of concurrence of UNFPA CP with UNFPA Strategic Plan, (2014-17 and 2018-21) policies and strategies, goals of ICPD PoA, and the SDGs.	1. UNFPA, ICPD and MDG, SDG policy and monitoring documents 2. Key Senior Policy informants within the four country/territory Ministries, UNCT and development partners.	1. Document review 2. Key stakeholder interviews. NB: The above for each of the four program areas).

changes in context of changes in national environment, SDGs, and b) respond to emergencies. The country has documents that should be ready for use for both types of changes. Did the country program actually respond as anticipated within the timelines etc.]			
EQ2.B Assumption 2:			
Assumption to be assessed	**Indicator/Criteria**	**Source of information**	**Method and tools for data collection**
EQ2.B Assumption 3: It is assumed that the UNFPA CP has explicitly attempted to attain consistency with the four separate areas: UNFPA policies, ICPD PoA, MDGs and the SDGs. NB: The SDGs were not adopted at the time of CPD drafting and approval.	1. Evidence of explicit commitments on the part of UNFPA CP team to achieve consistency with the four areas.	1. UNFPA, ICPD, MDG, SDG and Country PoC policy and monitoring documents. 2. Key informants.	1. Document review, 2. Key stakeholder interviews.
EQ2.B Assumption 3:			
EFFECTIVENESS (APPLIES TO ALL FOUR FOCUS AREAS)			
EQ3. To what extent have the intended programme outputs been achieved? To what extent did the outputs contribute to the achievement of these planned outcomes: (i). increased utilization of integrated SRH Services by those furthest behind, (ii). increased the access of young people to quality SRH services and sexuality education, (iii). mainstreaming of provisions to advance gender equality, and (iv). developing of evidence-based national population policies; and what was the degree of achievement of the outcomes?			
EQ3.A To what extent have the intended programme outputs been achieved?			
Assumption to be assessed	**Indicator/Criteria**	**Source of information**	**Method and tools for data collection**
EQ3.A Assumption 1: Assumes intended and unintended program outputs have been achieved to some extent.	1. Quantitative: Level of achievement against indicators/targets (as outlined in CP monitoring framework) over time within each of the four program areas: SRH, Youth, Gender and PD. 2. Qualitative: Stakeholder perceptions of achievement (quantity and quality) of outputs within each of the four program areas: SRH, Youth, Gender and PD	1. AWPs, COARs, Project Reports, CP, Revised CP Framework. 2. Stakeholders. 3. Most recent surveys and other available data within each of the four program areas: SRH, Youth, Gender and PD.	1.1 Document review. 1.2 Stakeholder interviews

	3. Good practices (strategy, achievement etc.)		
EQ3.A Assumption1: Findings including analysis for all pertinent program areas: 1. Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD.			
EQ3.B To what extent have the intended programme outcomes been achieved?			
Assumption to be assessed	**Indicator/Criteria**	**Source of information**	**Method and tools for data collection**
EQ3.B Assumption 1: Assumes all intended and unintended outcomes have been achieved to some extent.	1. Trend analysis (outcome indicators) to identify achievement of selected outcome indicators 2. Stakeholders' perspectives of changes (static/ positive/negative) 3. Stakeholders' perspectives on the most significant changes that have happened.	1. Secondary data (survey, census, reports etc.) 2. Stakeholders	1.1 Document review. 1.2 Stakeholder interviews
EQ3.B Assumption 1: Findings including analysis for all pertinent program areas: 1. Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD.			
Assumption to be assessed	**Indicator/Criteria**	**Source of information**	**Method and tools for data collection**
EQ3.B Assumption 2: Assumes that the majority of progress on intended outputs can be attributed to UNFPA CP. It is unlikely that all progress towards outputs can be attributed to a given intervention.	1. Evidence of pertinent program activity in allied non-UNFPA CP program areas.	Review of non-UNFPA program activities and trends on context for UNFPA CP activities.	1. Document review, 2. Stakeholder interviews, 3. Site visits, 4. Training follow-up and client/beneficiary interviews.
EQ3.B Assumption 2			
EFFECTIVENESS (THIS QUESTION APPLIES TO ALL FOUR FOCUS AREAS; BUT PRIMARILY TO SRH)			
EQ 4 To what extent has UNFPA contributed to an improved emergency preparedness in BiH, The former Yugoslav Republic of Macedonia, the Republic of Serbia, and Kosovo (UNSCR 1244), and in the area of maternal health / sexual and reproductive health including MISP?			
EQ4.A To what extent has UNFPA contributed to an improved emergency preparedness?			
Assumption to be assessed	**Indicator/Criteria**	**Source of information**	**Method and tools for data collection**
EQ4.A Assumption 1: There is an emergency preparedness plan, which is complete and updated.	1. Level of UNFPA contribution to emergency preparedness plan.	Stakeholders at National and sub-national level. Available data on emergency preparedness.	1. Document Review, 2. Stakeholder interviews.

EQ4.A Assumption 1: Findings including analysis for all pertinent program areas: 1. Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD, but primarily to SRH

EQ4.B Has UNFPA contributed to preparedness for MISP?

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
EQ4.B Assumption 1: UNFPA has contributed to MISP preparedness.	1. Level of UNFPA contribution to MISP	Stakeholders at National and sub-national level. Available data on emergency preparedness.	1. Document Review, 2. Stakeholder interviews.

EQ4.B Assumption 1: Findings including analysis for all pertinent program areas: 1. Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD, but primarily to SRH

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
EQ4.B Assumption 2 : The activities and outputs have contributed to a measurable and meaningful extent to the achievement pertinent to emergency preparedness, maternal health and SRH including MISP.	1. Pertinent indicators from CP Planning and Tracking Tool for output and outcome specific programme components pertinent to emergency preparedness, maternal health and SRH, including MISP. 2. Stakeholder qualitative perceptions on impact of activities and pertinent output impact on outcomes. 3. Client/beneficiary qualitative perceptions on impact of activities and output impacts on outcomes (It is acknowledged that that there is no direct UNFPA work with beneficiaries.)	1. Key stakeholders 2. Client beneficiaries 3. AWPs, 4. COARs, 5. National, Regional quantitative data 6. UNCT progress reports	1. Document Review 2. Stakeholder interviews within pertinent programme components, 3. Interviews and FGDs. 4. Secondary data analysis. (NB: The above for each of the pertinent areas).

EQ4.B Assumption 2:

EFFECTIVENESS (THIS QUESTION APPLIES TO ALL FOUR FOCUS AREAS; BUT PRIMARILY TO SRH, ASRH AND GE)

EQ5 To what extent has each office been able to respond to emergency situations in its Area of Responsibility (AoR), if one was declared? What was the quality and timeliness of the response?

Comment(s) on this question:

- This refers to all types of emergencies, not just GBV. Therefore, the interpretation needs to allow for a wider interpretation of this question, beyond GBV.

- The term AoR has been primarily focused on UNFPA leadership related to Gender-Based Violence Area of Responsibility (GBV AoR). UNFPA has been the sole lead for GBV AoR since 2016.

EQ5.A To what extent has each office been able to respond to emergency situations in its Area of Responsibility (AoR), if one was declared?

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
EQ5.A Assumption 1: UNFPA is able to respond to emergency situations if they are declared.	1. Measures of UNFPA emergency response preparedness.	1. UNFPA and UNDAF documents. 2. Government ministry documents pertaining to emergency response. 3. UNFPA, UNDAF and Government staff familiar with emergency response.	1. Document review and 2. Stakeholder interviews

EQ5.A Assumption 1: Findings including analysis for all pertinent program areas, but primarily to SRH, ASRH and GE

EQ5.B What was the quality and timeliness of the response?

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
EQ5.B Assumption 1: If UNFPA was asked to respond to an emergency situation, it responded with quality and in a timely fashion.	1. Evidence of the nature of a UNFPA response to an emergency situation.	1. UNFPA and UNDAF documents. 2. Government ministry documents pertaining to emergency response. 3. UNFPA, UNDAF and Government staff familiar with emergency response.	1. Document review and 2. Stakeholder interviews.

EQ5.B Assumption 1: Findings including analysis for all pertinent program areas, but primarily to SRH, ASRH and GE

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
EQ5.B Assumption 2: The UNFPA CP has encountered significant constraints as well as facilitating factors that both impeded and aided the achievement of results in the GBV AoR. (Need to point out that GBV is just one example of a type of emergency situation.) Need to prioritize all emergencies, including but not limited to GBV).	1. Contextual information related to constraints and facilitating factors for specific activities and outputs within the GBV AoR, but also for all other types of emergencies that UNFPA may have addressed.	1. Key informant interviews, 2. Trends in pertinent indicators. 3. COARs, 4. Implementing agency reporting 5. Media reports	1. Document review, 2. Stakeholder interviews with UNCT and IPs 3. Site visits, and Client Beneficiary interviews. 4. Secondary data analysis (NB: The above for each of the four program areas).

EQ5.B Assumption 2:

EFFICIENCY (APPLIES TO ALL FOUR FOCUS AREAS)

EQ6.To what extent has UNFPA made good use of its human, financial and technical resources, and has used an appropriate combination of tools and approaches to pursue the achievement of the results defined in the UNFPA programme documents?			
Comment(s) on above question: • There is an inherent subjectivity to the definition and measurement of what is "good use" of resources.			
EQ6.A To what extent has UNFPA made good use of its human, financial and technical resources to pursue the achievement of the results defined in the UNFPA programme documents?			
Assumption to be assessed	**Indicator/Criteria**	**Source of information**	**Method and tools for data collection**
EQ6.A Assumption 1: UNFPA has made good use of its human, financial and technical resources to pursue the achievement of results defined in UNFPA programme documents.	1. Amount of resources used to achieve the outputs/outcomes, compared to the value of achieved outputs. 2. The planned inputs and resources were received as set out in the AWPs and agreements with partners. 3. The resources were received in a timely manner according to timeline set in the agreement. 4. Inefficiencies were corrected as soon as identified. 5. Trend analysis: Implementation rate, Distribution by sector/outcome 6. Access of internal or external human/technical resources to enhance programme effectiveness 7. Timely and quality TA provisions	1. Key stakeholders; 2. Documentation of programme inputs by category (human, financial, technical). 3. Feedback on quantity and quality of TA provided to implementing agencies. 4. Atlas data.	1. Key stakeholder interviews 2. Document review 3. Budget review.
EQ6.A Assumption 1: Findings including analysis for all pertinent program areas			
EQ6.B To what extent has UNFPA used an appropriate combination of tools and approaches to pursue the achievement of the results defined in the UNFPA programme documents?			
Assumption to be assessed	**Indicator/Criteria**	**Source of information**	**Method and tools for data collection**
EQ6.B Assumption 1: UNFPA has used an appropriate combination of tools and approaches to pursue the achievement of the	1. Amount of human, financial and technical tools and approaches used to achieve the outputs/outcomes,	1. Key stakeholders;	1. Key stakeholder interviews,

results defined in the UNFPA programme documents.	compared to the results achieved in outputs/outcomes.	2. Documentation of programme inputs by category (human, financial, technical). 3. Feedback on quantity and quality of TA provided to implementing agencies. 4. Atlas data.	2. Document review, 3. Budge review.
EQ6.B Assumption 1: Findings including analysis for all pertinent program areas			
Assumption to be assessed	**Indicator/Criteria**	**Source of information**	**Method and tools for data collection**
EQ6.B Assumption 2: UNFPA CPs have expended resources to achieve outputs at a level that is consistent with standard norms for the cost of implementing program activities in each of the four program areas.	1. Amount of resources used to achieve the activities, outputs as compared to the standard norms for the cost of achieved outputs.	1. Key stakeholders; 2. Documentation of programme inputs by category (human, financial, technical). 3. Feedback on quantity and quality of TA provided to implementing agencies. 4. Atlas data. 5. COARs 6. IP reporting data. Training data.	1.Key stakeholder interviews, 2.Document review 3.Budget review of sentinel activities vs budget in AWPs. (NB: The above for each of the four program areas).
EQ6.B Assumption 2:			
SUSTAINABILITY (APPLIES TO ALL FOUR FOCUS AREAS)			
EQ7 Are programme results sustainable in short and long-term perspectives? NB: 3 years or less = short term. More than 3 years = long term.			
Comment(s) on above question: • For the purpose of this work, it is assumed that programme results are sustainable (short-term refers to up to three years, long-term is greater than three years.) Short-term and long term are somewhat subjective in nature and require a combination of qualitative and quantitative indicators to measure. Each can be addressed with a combination of quantitative and qualitative assessment approaches.			
Comment(s) on indicators for above question: • Short-term sustainability - Short-term ability of institutions to continue functions without external support. - Measures of capacity building, esp. training activities. - Measures of ownership: Patterns of staffing turnover - Counterpart agency sources of budget, current and future. • Long-term sustainability can be measured quantitatively via the level of fund-raising or cost-sharing achieved by a UNFPA donor recipient has achieved for a given activity. Qualitatively, stakeholders provide their subjective impressions on the buy-in, ownership and institutional commitment of a UNFPA donor recipient to continue a given program activity in the absence of future UNFPA support.			

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
EQ7 Assumption 1: The UNFPA CP has supported programs that have results that can be sustained in the short- and long-term (up to three years and greater than three years) in each of the four program areas.	1. Short-term and long-term ability of institutions to continue functions without external support. 2. Measures of capacity building, esp. training activities that endure for short versus long-term. 3. Patterns of staffing turnover 4. Counterpart agency sources of budget over time.	1. CCA 2015 2. UNFPA CP COARs, AWPs, 3. Implementing agency reports. 4. Training data. 5. Stakeholders in management positions within Ministry and IPs 6. Client beneficiaries.	1.Key stakeholder interviews, 2.Training follow-up interviews 3.Client/beneficiary interviews 4.Document review 5.Budget review. (NB: The above for each of the four program areas).
EQ7 Assumption 1:			
SUSTAINABILITY (APPLIES TO ALL FOUR FOCUS AREAS)			
EQ8 To what extent have the partnerships established by UNFPA promoted the national ownership and sustainability of supported interventions, programmes and policies?			
Comment(s) on above question: • Data will be collected on partnerships established by UNFPA to assess national ownership and sustainability of supported interventions, programmes, and policies. In some cases, it may be difficult to distinguish interventions from programmes and policies. The evaluation will rely in part on self-reports of partnership stakeholders, which may be biased toward making a favourable impression to donors.			
Comment(s) on indicators for above question: • Short- and long-term sustainability of UNFPA supported partner institutions to continue, replicate or adapt programme functions without external support. Measures of national ownership and sustainability in different types of interventions, programmes and policies.			
Assumption to be assessed	**Indicator/Criteria**	**Source of information**	**Method and tools for data collection**
EQ8 Assumption 1: The UNFPA CP has succeeded in developing partnerships that promote the national ownership and sustainability of supported interventions, programmes and policies. Comment on Assumption to be assessed for question. In some countries it may be that there are not many partnerships that have been successfully established by UNFPA.	1. Short and Long-term ability of UNFPA supported partner institutions to promote national ownership and sustainability of supported interventions, programmes and policies. 2. Measures of capacity building, esp. training activities. 3. Patterns of staffing turnover and counterpart agency	1. National Ministry Strategic Planning documents, 2. UNFPA CP, COARs, AWPs, 3. Implementing agency reports. 4. Training data. 5. Stakeholders in management positions and beneficiaries.	1. Key stakeholder interviews with Senior policy makers within Ministry and IPs, 2. Document review, 3. Budget review. 4. Training follow-up interviews. (NB: The above for each of the four program areas).

	4. Long-term budgeting over time (evidence of Ministry or other entity buy-in).		
EQ8 Assumption 1:			
COMPONENT 2: ANALYSIS OF UNFPA Country Programme UNCT Cooperation and Value Added			
UN COUNTRY TEAM COORDINATION			
EQ9 To what extent did UNFPA contribute to coordination mechanisms in the UN system at country level? **Example: Results teams led or assisted by UNFPA.**			
Assumption to be assessed	**Indicator/Criteria**	**Source of information**	**Method and tools for data collection**
EQ9 Assumption 1: The UNFPA CO has made consistent positive contributions to the consolidation and functioning of UNCT coordinating mechanisms (working groups and joint programs) toward implementation of the UNDAF in each of the four program areas.	Reported level of UNFPA CO staff participation in: 1. UNCT planning and coordination functions. 2. Pertinent UNCT theme groups 3. Other UNCT administrative bodies for coordination of activities. 4. Concrete examples of UNFPA CO participation in the process of consolidation of UNCT coordination procedures and programs.	1. UNCT staff at senior management and theme group levels. 2. UNCT Theme group minutes	1. Stakeholder interviews with UNRC and members of UNCT theme groups and UN agencies. 2. Document review of coordination of joint program activities (NB: The above for each of the four program areas).
EQ9 Assumption 1:			
UNCT COOPERATION			
EQ10 To what extent does the UNDAF/UN Partnership Framework, reflect the interests, priorities and mandate of UNFPA?			
Assumption to be assessed	**Indicator/Criteria**	**Source of information**	**Method and tools for data collection**
EQ10 Assumption 1: UNFPA global mandates are being effectively implemented within the UNDAF in all four program areas.	1. Mapping of key global UNFPA (e.g. SP 2014-2017 and SP 2018-2021) mandates and priorities within UNDAF strategic documents and annual program activities for each of the four program areas.	1. UNFPA Global Strategy documents (UNFPA SP 2014-2017 and SP 2018-2021) 2. Senior UNFPA CO and UNCT management, 3. UNDAF strategy and reporting documents 4. UNDAF Midterm review, 5. UNDAF Annual Reports.	1. Document review, 2. Key stakeholder interviews with UNFPA CO staff as well as UNCT (UNRC and theme group members). (NB: The above for each of the four program areas).

		6. UNFPA CP COARS	
EQ10 Assumption 1:			
COMPONENT 3: ANALYSIS OF THE CP's STRATEGIC POSITIONING			
UNCT COORDINATION			
EQ11 To what extent did UNFPA contribute to ensuring programme complementarity, seeking synergies and avoiding overlaps and duplication of activities among development partners working in countries?			
Comment(s) on above question: • Alignment with UNFPA mandates may have changed over time due to the 2018 -2021Aligned CP Output and Outcomes framework.			
Comment(s) on indicators for above question: • Congruence of UNDAF and UNCT activities, outputs and outcomes with the 2018 - 2021 UNFPA Aligned CP framework. Qualitative data on UNCT recognition of UNFPA CO contributions to UNDAF.			
EQ11.A To what extent did UNFPA contribute to ensuring programme complementarity, seeking synergies and avoiding overlaps and duplication of activities among development partners working in countries?			
Assumption to be assessed	**Indicator/Criteria**	**Source of information**	**Method and tools for data collection**
EQ11.A Assumption 1: UNFPA has contributed to ensuring program complementarity, seeking synergies and avoided overlaps and duplication of activities among development partners.	1. Congruence of UNDAF and UNCT activities, outputs and outcomes with the 2018 - 2021 UNFPA Aligned CP framework. Qualitative data on UNCT recognition of UNFPA CO contributions to UNDAF.	1. Senior UNFPA staff management, 2. CPD, 3. UNDAF documents, 4. UNDAF Midterm review, 5. UNCT Annual Reports.	1. Document review, 2. Key stakeholder interviews.
EQ11.A Assumption 1: Findings including analysis for all pertinent program areas: 1. Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD.			
Assumption to be assessed	**Indicator/Criteria**	**Source of information**	**Method and tools for data collection**
EQ11.A Assumption 2: The UNFPA CP's core mandated activities, outputs and outcomes as implemented within the Country's UNDAF are recognized and acknowledged by UNCT.	1. Congruence of UNDAF and UNCT activities, outputs and outcomes with the 2018 - 2021 UNFPA Aligned CP framework. 2. Qualitative data on UNCT recognition of UNFPA CO contributions.	1. Senior UNFPA staff management, 2. Senior UNCT staff (UNCR and theme group members) UNFPA CP and PoC documents, 3. UNDAF Midterm review, UNCT Annual Reports. UNCT theme group minutes.	1. Document review, 2. Key stakeholder interviews with UNCT senior staff as well as UNFPA CO staff. (NB: The above for each of the four program areas).
EQ11.A Assumption 2:			
ADDED VALUE			
EQ12 What is the main UNFPA added value in the country context as perceived by national stakeholders?			
Assumption to be assessed	**Indicator/Criteria**	**Source of information**	**Method and tools for data collection**

EQ12 Assumption 1: Assumes that UNFPA has added value in one or more areas within the country context.	1. Examples of activities that were influential for the results in a program area. 2. The perceptions of key national stakeholders.	1. Senior stakeholders at GVT Ministries, UNCT, UNFPA CO, and IP agencies 2. UNFPA program reporting documents. 3. Site Visits	1. Document review 2. Key stakeholder interviews
EQ12 Assumption 1:			