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**UNFPA Country Programme Evaluation
Tajikistan
CP Period: 2016-2020
FINAL EVALUATION REPORT**

December 27, 2019



Map of Tajikistan



Source: United Nations Geospatial Information Section
<https://www.un.org/Depts/Cartographic/map/profile/tajikist.pdf>

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Disclaimer

This was an independent external evaluation, so the analysis and recommendations of this report are the product of the evaluation team and do not necessarily reflect the views of the United Nations Population Fund.

Acknowledgement

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
AS	Agency on Statistics under the President of the Republic of Tajikistan
AWP	Annual Work Plan
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CC	Cervical Cancer
CSO	Civil Society Organization
CO	UNFPA Country Office
COAR	Country Office Annual Report
CP	UNFPA Country Programme
CPD	UNFPA Country Programme Document
CRVS	Civic Registry and Vital Statistics
DEX	Direct Execution
DRS	Districts of direct subordination
DHS	Demographic and Health Survey
DV	Domestic Violence
EmOC	Emergency Obstetrics Care
EQ	Evaluation Question
ERG	Evaluation Reference Group
EPC	Effective Perinatal Care
FP	Family Planning
GA	Global Assessment of the National System of Official Statistics of the Republic of Tajikistan
GBV	Gender Based Violence
GDP	Gros Domestic Product
GE	Gender Equality
GII	Gender Inequality Index
GIS	Geographic Information System
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GNI	Gross National Income
HBSC	Health-behavior of school-aged children
HDI	Human Development Index
HIV	Human Immuno-deficiency Virus
HLS	Healthy Life Style
ICPD	International Conference on Population and Development
ICPD PoA	ICPD Programme of Action
IUD	Inter-Uterine Device
IP	Implementing partner
FDG	Focus Group Discussion
FP	Family Planning
MMR	Maternal Mortality Ratio
MoE	Ministry of Education
MoJ	Ministry of Justice
MoHSP	Ministry of Health and Social Protection
MoFA	Ministry of Foreign Affairs
MSM	Men who have sex with men
MTDP	Mid-term Development Program
NDC	National Development Strategy
NEX	National Execution
NGO	Non-Governmental Organization

NMCR	Near-Miss Cases Review
OECD DAC	OECD Development Assistance Committee
PD	Population and Development
PHC	Primary Health Care
PRS	Poverty Reduction Strategy
REACT	Rapid Emergency Assessment & Coordination Team
RH	Reproductive Health
RHC	Reproductive Health Center
SDC	Swiss Agency for Development and Cooperation
SDGs	Sustainable Development Goals
SOP	Standard of practice
SP	UNFPA Strategic Plan
SRH	Sexual and reproductive health
SI	Spotlight Initiative
STI	Sexually transmitted infections
SW	Sex worker
TFPA	Tajik Family Planning Alliance
ToR	Terms of Reference
ToT	Training of Trainers
TP	Trust Point
VNR	Voluntary National Report
VSR	Victim Support Room
UNAIDS	UN Joint Programme on AIDS
UNCT	UN Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	US Agency for International Development
WHO	World Health Organization
YFC	Youth Friendly Clinic

Box 1. Structure of the Evaluation of the Tajikistan UNFPA Country Programme 2016-2020

This report includes executive summary, six chapters, and annexes presented separately. Report structure follows recommendations provided in the UNFPA Evaluation Handbook “How to design and conduct a country programme evaluation” (2019 edition).

Chapter 1, **Introduction**, presents evaluation purpose and scope and describes evaluation process, methodology and methodology limitations.

Chapter 2, **Country context**, discusses situation and recent development in Tajikistan related to the focus areas of the country programme, as well as factors influence provision of development assistance.

Chapter 3, **UNFPA response and country programme for Tajikistan 2016-2020**, describes design of the UNFPA country programme, and its financial structure.

Chapter 4, **Findings**, presents answers to evaluation questions.

Chapter 5, **Conclusions**, presents strategic level conclusions explicating key success and failure factors emerging from the evaluation findings as well as programmatic level conclusions on the overall progress achieved by the programme.

Chapter 6, **Recommendations**, presents strategic and programmatic level recommendations.

Annexes include terms of reference, list of persons met, list of consulted documents, evaluation matrix and data collection instruments.

The report was not professionally edited.

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Key facts table

Land	
Geographical location	Central Asia
Land area	142 600sq km (2014) ¹ / 143 100 sq km (2019) ² 141 400 sq km (2018) ³
Border countries	Afghanistan, China, Kyrgyzstan, Uzbekistan
People	
Population	9.127 million (2019) ^{***}
Life expectancy at birth	71.2 (2017) ⁴ 74.9 (2017) ³
Urban population (%)	27.0% (2017) ⁴ 26.3 % (2017) ³
Economy	
Gross national income (GNI) per capita (2011 PPP \$)	3,317 (2017) ⁴
GDP per capita (2011 PPP \$)	2,897 (2017) ⁴
GDP annual growth (%)	4.9 (2017) ⁴
Social indicators	
Human Development Index	0.650 (2017) ⁴
Employment to population ratio (% ages 15 and older)	53.2 (2017) ⁴ 60.3 (2017) ³
Youth unemployment (% ages 15–24)	18.9 (2017) ⁴ 19.5 (2017) ³
HIV prevalence rate – adults (% ages 15–49)	0.3 (2017) ⁴
Perception of health care quality (% satisfied)	80 (2017) ⁴
Government expenditure on education (% of GDP)	5.2 (2017) ⁴
Birth registration (% under age 5)	88 (2017) ⁴
Internet users (% of population)	20.5 (2017) ⁴
Mobile phone subscriptions ((per 100 people)	107.6 (2017) ⁴

¹ http://data.un.org/CountryProfile.aspx/_Images/CountryProfile.aspx?crName=Tajikistan.

² Ministry of Foreign Affairs of the Republic of Tajikistan <https://mfa.tj/ru/main/tadzhikistan/obshchaya-informatsiya>

³ Agency on Statistics under the President of the Republic of Tajikistan. Demographic yearbook of the Republic of Tajikistan, 2018.

⁴ UNDP (2018). Human Development Indices and Indicators: 2018 Statistical Update.

SDGs/ Targets	Indicator/ Source	Status*
Goal 3. Ensure healthy lives and promote well-being for all at all ages	3.1.1 Maternal mortality ratio	24
	3.1.2 Proportion of births attended by skilled health personnel	94.8
	3.7.1 Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods	52.2
	3.7.2 Adolescent birth rate (aged 15–19 years) per 1,000 women in that age group	54
Goal 5. Achieve gender equality and empower all women and girls	5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a	24.1

	current or former intimate partner in the previous 12 months	
	a) Physical violence	18.7
	b) Sexual violence	1.4
	c) Psychological violence	13.3
	5.3.1 Proportion of women aged 20–24 years who were married or in a union:	
	a) before age 15	0.1
	b) before age 18	8.7
	5.6.1 Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care	27.2
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	16.9.1 Proportion of children under 5 years of age whose births have been registered with a civil authority	95.8

*Source: Tajikistan Demographic and Health Survey (2017)¹.

¹ 2017 Tajikistan Demographic and Health Survey (DHS 2017) was implemented by the Agency on Statistics under the President of the Republic of Tajikistan with USAID financial support. Additional funding as well as technical support for the survey was provided by UNICEF and UNFPA.

Executive summary

This report presents the findings of the final evaluation of the UNFPA Country Programme (CP) for Tajikistan 2016-2020. The overall objectives of this evaluation are: (i) an enhanced accountability of UNFPA and its country office for the relevance and performance of its country programme and (ii) a broadened evidence-base for the design of the next programming cycle.

The specific objectives are:

- To provide an independent assessment of the progress of the country programme towards the expected outputs and outcomes set forth in the results framework of the respective country programme;
- To provide an assessment of country office (CO) positioning within the developing community and national partners, in view of its ability to respond to national priority needs while adding value to the country development results.
- To draw key lessons from the past and current cooperation and provide a set of clear, specific and action-oriented forward-looking strategic recommendations in light of agenda 2030 for the next programming cycle.

The primary users of this evaluation are the decision-makers within the UNFPA country office in Tajikistan and organization as a whole, government counterparts in the country, the UNFPA Executive Board, 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 covered Tajikistan and the following four programmatic areas: Reproductive Health, Adolescents and Youth, Gender Equality and Population and Development. The evaluation will cover all activities planned and/or implemented during the period 2016-2019. Cross-cutting areas will include partnership, resource mobilization and communication.

The evaluation analyzed 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.

Methodology

Evaluation design was informed by analysis of the country programme strategic intent, including reconstruction of the theory of change, and mapping of programme stakeholders and available documentation. Evaluation data was collected through review of relevant documentation as well as semi-structured interviews and focus groups with 262 programme stakeholders conducted in Dushanbe and selected sites in Khatlon and Sugd provinces on September 11 – October 4, 2019.

Based on the analysis and triangulation of the data collected from different sources the evaluation team has developed evaluation findings and constructed answers to the evaluation questions. Evaluation conclusions and recommendations were developed in consultation with Evaluation Reference Group and UNFPA Country Office.

Findings

Relevance

CP design was informed by the analysis of the population needs in the UNFPA focus areas. In the course of the CP implementation UNFPA supported assessments that informed adaptation of UNFPA support to the needs of the population, including the needs of the most vulnerable groups. National stakeholders and CP beneficiaries confirmed that UNFPA support through the CP is well adapted to the needs of the target populations.

UNFPA support is in line with the majority of the key areas for future action identified in the Framework of Actions for the follow-up to the Programme of Action of the International Conference on Population and Development Beyond 2014.

The CP contributes to achievement of all three transformative goals established by the UNFPA strategic plan. UNFPA CO put specific attention to reaching the furthest behind through introducing innovative approaches to increase the access of vulnerable groups to SRHR and legal services in remote areas.

Within the framework of this CP, UNFPA used all relevant operational modalities, including service delivery, but used an integrated approach considering the country needs and context when several operational modalities were combined within the framework of every intervention and maintained a strong focus on advocacy and policy dialogue and capacity development.

CP is well aligned with priority approaches emphasized in the UNDAF document. There is a direct alignment between the CP results and intended results set forth by the original version of UNDAF 2016-2020. The revised UNDAF results framework adopted in 2019 captured and expanded UNFPA CP results.

Effectiveness

The CP has reached all targets for its outputs and outcomes in the SRH, Adolescents and Youth and Gender focus areas as well as majority of the targets for the Population dynamics focus area as well as made achievements beyond the initial programme results.

UNFPA supported the development of a number of important policy documents in the SRH and Adolescent and Youth areas. UNFPA support was also instrumental for development and adoption of a set of SOPs that regulate comprehensive multi-sectoral response to GBV. UNFPA played a key role in developing national instruments integrating issues of population dynamics.

Efficiency

CO pursued the achievement of the results defined in the UNFPA country programme despite of lack of human resources by using an adaptive management approaches and strongly contributed to increase of UNFPA visibility in the country and UNCT coordination.

Strategic cooperation with government partners, the National Population and Development Committee under the Parliament and integration with existing national systems and processes facilitated high efficiency of the use of UNFPA financial resources.

Sustainability

The evaluation has found that UNFPA is consistently using results based approaches that promote national ownership and institutionalization of UNFPA supported interventions through: (i) regular consultations with stakeholders; (ii) building on national systems and processes, (iii) advocacy and supporting dialogue between national stakeholders on developing policy frameworks and strategies based on ICPD and SDG principles; and (iv) national execution of supported interventions; (v) UNFPA focused on long-term results and sustainability by integrating international standards and evidence based programmes into national policy frameworks, strategies and educational programmes.

In most cases, UNFPA operation is not project-based and UNFPA is able to provide long-term continuous support to ensure sustainable implementation and ongoing improvement of the practices introduced with its support. Low operational costs of practices introduced with UNFPA also facilitate their sustainable implementation by government institutions. At the same time, high staff turnover and lack of knowledge in policy application by national institutions may affect sustainability of UNFPA supported interventions. The fact that government institutions organize their internal training events contributes towards scaling up the reach of capacity building interventions supported by UNFPA.

UNCT coordination

In 2016-2019 UNFPA CO participated in and contributed to all UNCT coordination mechanisms, including Operations Management Team, UN Communication Group, Theme Groups, UNDAF Results Groups, REACT, Spotlight initiative. UNFPA CO contribution is recognized by other agencies and RCO.

Added value

In the context of Tajikistan UNFPA added value stems from its thematic leadership in the SRH, including maternal health and family planning, Population and development and long-term consistency of UNFPA support combined with responsiveness to the needs of national context and priorities and operational flexibility.

Conclusions

- 1:** UNFPA CP is well aligned with national priorities of Tajikistan, UNDAF results and National Development Strategy, UNFPA strategic areas, ICPD and SDG objectives, addressed country needs by introducing innovative approaches and focusing on needs of vulnerable groups using an adaptive management approach.
- 2:** In the frame of CP results, CO made special focus on policy dialogue and evidence based advocacy involving all relevant political and social channels, cooperating with UN and non-UN Agencies that resulted in achieving CP targets and increased UNFPA visibility in the country. UNFPA maintained strong strategic partnership towards achieving three transformative goals by advocating for development and approval of new policies and strategies and mobilizing additional resources.
- 3:** UNFPA support was crucial in terms of ensuring uninterrupted supply of contraceptives and access to contraceptive by women in remote areas.
- 4:** The joint efforts of MoHSP, UNFPA and USAID was the best example of partnership that brought evidence to policy makers to establish a dedicated budget line for procurement of contraceptives.
- 5:** UNFPA contribution is aligned with the human rights-based approach on elimination of preventable maternal mortality and morbidity according to Human Rights Council resolution 18/2 (2011) that is underpinned by the principles of accountability, participation, transparency, empowerment, sustainability, non-discrimination and cooperation.
- 6:** Pilot project on cervical cancer prevention provided strong evidence on its effectiveness and efficiency towards ending preventable death among women and this model project is applicable to for expansion in other regions.
- 7:** UNFPA has rightly focused on the health and well-being of key population. It is one of very few organizations to speak up and provide support for harassed and hushed up sex workers (SWs) and men who have sex with men (MSM).
- 8:** UNFPA has successfully promoted an increased priority on young people in national development policies, as such providing a further platform for institutionalization of the HLS into the education sector of the country;
- 9:** UNFPA support was instrumental in establishing multi-sectoral cooperation and response to GBV through introducing UN Global Essential Service Package and Standard Operating Procedures for health, police and psychosocial services that is strengthened the referral system.
- 10:** CP introduced innovative approaches focusing on community of educated clients and bringing quality social and legal services close to remote rural areas reaching those who left behind.
- 11:** UNFPA provided support to Agency on Statistics in the past was crucial and further capacity building, policy dialogue and knowledge management initiatives are important for successful conduction of the PHC. The further priorities and UNFPA value added will be an effort to make available nationwide and reliable socio-demographic data and their use for development of strategies and policy programmes/documents, investment programme, as well as sectoral planning and budgeting.

12: During the first phase of the Civil Registration Project Reform UNFPA contributed to all outputs (except output 4) and both outcomes of the project by providing technical assistant and expertise by conducting several and consecutive activities in cooperation with CSOs. To ensure ownership and sustainability of the program it is crucial to maintain effective partnership with the Government and UN Sister agencies. Moreover, to assess the overall level of achievements almost impractical without contribution of UNDP and UN-Women made since 2016. Therefore, consolidated Final Report prepared and submitted by UNDP to SDC should elaborate more on overall Project achievements propose the recommendations for second phase of the Project.

13: UNFPA has made huge affords to establish the official Thematic SRH Working Group under the MoHSP and introduce multi-sectoral GBV prevention platform, which are operational and practically effective.

Recommendations

1: UNFPA should further strengthen integrated approach for results-based management to enhance programme effectiveness by participatory approach involving national partners and beneficiaries to programme design, implementation and monitoring, ensuring organizational consistency to country context, focusing on efficiency and continuity, advocating for mutual accountability and transparency.

2: UNFPA should strengthen UNFPA CO Coordination, Advocacy and Strategic Partnerships and develop CO Communication and Advocacy (CA) Strategy based on UNFPA CA Strategy in the context of Nairobi commitments and country context. CO should consider partnership with traditional and non-traditional partners including private sectors.

3: Ensure a focused rights-based approach on FP and expand the range of modern contraceptive methods to maximize the efficiency of FP programme, and to position FP as an integral part of UHC.

4: Use available mechanisms for sustainability of FP interventions by developing and integrating an exit strategy such as the State Programme on RH.

5: The UNFPA-supported evidence based programmes are essential for making a lifesaving and long-lasting impact on women's and child's health and eliminating preventable maternal and newborn morbidity and mortality. The next CP should continue human rights based and integrated approaches in mother and child health with particular attention to district and rural areas based on quality data.

6: UNFPA should continue efforts on expansion of cervical cancer prevention programme in Tajikistan in the frame of elimination of preventable death and diseases among women

7: Considering the fact, that HIV is on the rise in the country, it is recommended to continue to work with SW and MSM including on STI prevention and knowledge management.

8: Education sector of the country is mandated to equip children and young people with the knowledge, skills and attitudes they need to live safe and healthy lives. Since importance of comprehensive sexual and reproductive health education has been recognized as an integral component of the healthy lifestyle education programmes, it is necessary to promote further institutionalization of the HLS.

9: UNFPA should continue efforts on institutionalization the multi-sectoral cooperation response to GBV/SGBV against women and girls with particular focus on leaving no one behind in the context of SDG principles

10: Coherent, reliable and internationally comparable statistics are important for the monitoring of social and economic progress of a country and UNFPA by supporting of 2020 PHC will contribute on availability nationwide age-sex and spatial disaggregated socio-economic and demographic data to monitor country's development agenda, and monitoring of SDGs and NDS indicators.

11: Strengthen UNFPA humanitarian priorities at the national preparedness and response plans in accord with the framework of UNSDCF and UHC linking with the Sustainable Development Agenda and targets and priorities set by the Sendai Framework for DRR 2015-2030.

CHAPTER 1: Introduction

1.1 Purpose and objectives of this evaluation

The overall objectives of this evaluation are: (i) an enhanced accountability of UNFPA and its country office for the relevance and performance of its country programme and (ii) a broadened evidence-base for the design of the next programming cycle.

The specific objectives are:

- To provide an independent assessment of the progress of the country programme towards the expected outputs and outcomes set forth in the results framework of the respective country programme;
- To provide an assessment of country office (CO) positioning within the developing community and national partners, in view of its ability to respond to national priority needs while adding value to the country development results.
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The primary users of this evaluation are the decision-makers within the UNFPA country office in Tajikistan and organization as a whole, government counterparts in the country, the UNFPA Executive Board, 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.

1.2 Scope of the evaluation

As per the ToR (Annex 1) the evaluation covered Tajikistan and the following four programmatic areas: Reproductive Health, Adolescents and Youth, Gender Equality and Population and Development. The evaluation will cover all activities planned and/or implemented during the period 2016-2019. Cross-cutting areas will include partnership, resource mobilization and communication.

The evaluation analyzed 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.

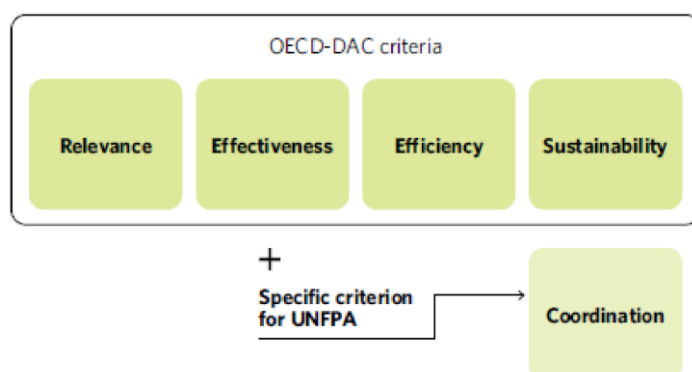
1.3 Methodology and process

This section presents an overview of the methodology used by the evaluation team, including evaluation criteria and questions, evaluation process, sample, methods for data collection and analysis, as well as evaluation limitations and related mitigation measures.

1.3.1 Evaluation criteria and questions

This evaluation was structured around four OECD-Development Assistance Committee (DAC) criteria of relevance, effectiveness, efficiency and sustainability, as well as a criterion of coordination specific to UNFPA (Fig. 1). In addition, the evaluation had to assess the added value of the UNFPA Country programme.

Figure 1. Evaluation criteria.



Source: UNFPA Evaluation Handbook (2019).

During the preparatory phase UNFPA country office in Tajikistan has developed a set of evaluation questions related to the above criteria that was reviewed and approved by the regional evaluation advisor (Table 1).

Table 1. Evaluation questions.

Criteria	Evaluation questions
Relevance	EQ1. To what extent is the UNFPA support (i) adapted to the needs of the population with emphasis to the most vulnerable population (ii) in line with the priorities set by ICPD Plan of Action and national policy frameworks related to UNFPA mandated areas, (iii) aligned with the UNFPA strategic plan in particular Strategic plan principles (leaving no one behind and reaching the furthest behind), transformative goals, and business model and (iv) aligned with the UN Partnership Framework?
Effectiveness	EQ2. To what extent have the intended programme outputs been achieved? EQ3. 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 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? EQ4. To what extent has UNFPA policy advocacy and capacity building support helped to ensure that sexual and reproductive health (including Family Planning), and the associated concerns for the needs of young people, gender equality, and relevant population dynamics are appropriately integrated into national development instruments and sector policy frameworks in the programme country?
Efficiency	EQ5. 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 country programme?
Sustainability	EQ6. To what extent have the partnerships established with ministries, agencies and other representatives of the partner government allowed the country office to make use of the comparative strengths of UNFPA, while, at the same time, safeguarding and promoting the national ownership of supported interventions, programmes and policies? EQ7. To what extent have partnerships built with government or other UN organizations helped to enhance sustainability or scale up interventions and/or bring relevant evidence to policy-makers to adopt such approaches?
UNFPA CP coordination with UNCT	EQ8. To what extent has the UNFPA country office contributed to the functioning and consolidation of UNCT coordination mechanisms?

UNFPA CP added value	EQ9. What is the main UNFPA added value in the country context as perceived by UNCT and national stakeholders?
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1.3.2 Methodology

Methodology used by the evaluation team was based on the recommendations and guidance provided by the UNFPA Evaluation Handbook², as well as UNEG Guidance Document “Integrating Human Rights and Gender Equality in Evaluation: Towards UNEG Guidance”. Evaluation Matrix (Annex 5) presents a detailed overview of evaluation methodology.

In the course of this evaluation the evaluation team has followed the UNEG Ethical Guidelines (2008) and Norms for Evaluation in the UN System (2016).

Evaluation process

The evaluation included three main phases: (i) design phase; (ii) field phase; and (iii) synthesis and dissemination phase. The evaluation team started the **design phase** with the inception interviews with the staff of the UNFPA country office to get understanding of the set of interventions implemented within the framework of the country programme and involved stakeholders. Then the evaluation team reviewed documentation provided by the country office. Results of this analysis informed reconstruction of the programme logic, development of the stakeholder map and design of evaluation methodology that was presented in the inception report and discussed with the CO and ERG.

The **field phase** took place on September 11 – October 4, 2019. The evaluation team worked in the national capital of Dushanbe and selected CP sites in Khatlon and Sugd provinces. In the course of the data collection mission the evaluation team conducted individual and group interviews and focus groups with 262 CP stakeholders. The evaluation team was also able to attend and observe one of the round tables organized within the framework of the CP in the city of Khudjand, the capital of Sugd province. In the end of the data collection phase the evaluation presented preliminary finding and emerging conclusions and recommendations to the CO.

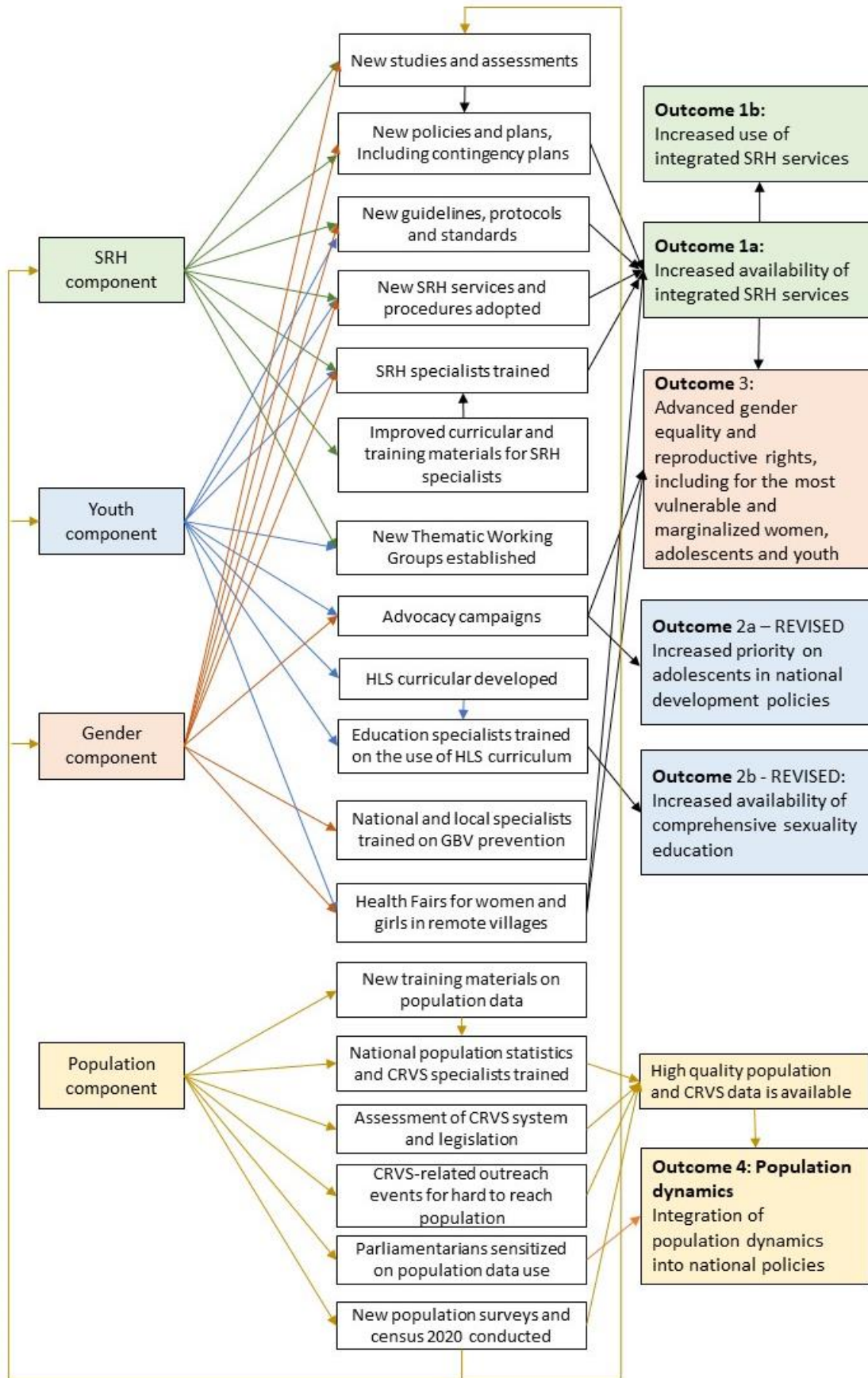
During the **synthesis and dissemination phase** the evaluation team carefully analyzed all collected data and triangulated information from different sources to arrive at the evaluation findings, conclusions and recommendations and prepared the first draft of the evaluation report. This draft was reviewed by the CO and key findings, conclusions and recommendations were presented to and discussed with members of the ERG. The final version of the evaluation report was developed with consideration of the comments of the CO and the ERG.

Reconstruction of the programme logic

Reconstructed programme logic was one of the products of the evaluation design phase. Original outputs presented in the Country Programme Document are broadly formulated as increased national capacity in the programme focus areas. Based on the analysis of the country programme documentation, including AWP, COARs, Partnership Plan, Resource Mobilization Plan and Reports of Technical experts (assessments, advocacy missions etc.), the evaluation team identified a number of direct measurable intended results of the country programme activities that were consistently measured in the course of the programme and identified their linkages with the country programme outcomes (Fig. 2).

² UNFPA Evaluation Handbook. How to design and conduct a country programme evaluation. 2019 edition.

Figure 2. Reconstructed Theory of Change.



The analysis has revealed that specific initiatives/interventions implemented within the framework of the country programme usually contribute towards several of the above-mentioned direct results. For example, the pilot project that introduced cervical cancer (CC) screening and early treatment in two districts produced a comprehensive assessment of the CC services, trained RH specialists on CC diagnostics and prevention, developed related clinical protocols and conducted several information campaigns to raise awareness about CC and importance of early screening. Pilot CCP project made achievements beyond the initial project objectives and model of inter-sectoral approach is developed on SRHR and gender equality. This programme was recognized by the National Population and Development Committee under the Parliament of Tajikistan. A number of other Reproductive health issues (contraception, myoma, extragenital diseases, etc.) were identified and addressed. Capacity building activities contributed to improvement of overall SRH services that meet internationally agreed evidence-based standards and significantly contributed to the institutionalization and sustainability of the SRH programme.

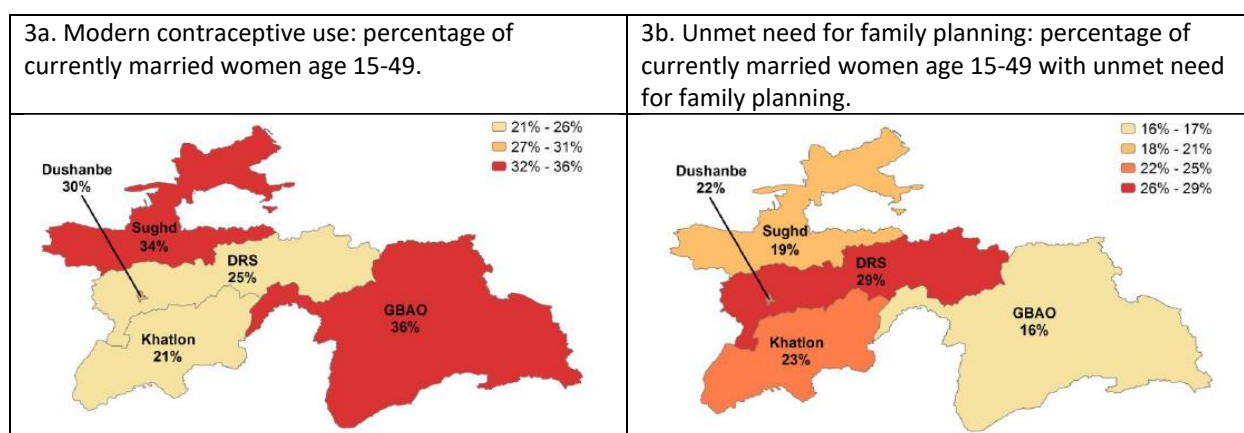
The analysis has also revealed that SRH, Youth and Gender components of the country programme are closely linked and all contribute towards greater availability of integrated SRH services. For example, under Youth component UNFPA provided technical assistance to the Ministry of Health and Social Protection with the development of the Decree “On provision of the medical services and counseling on RH to adolescents, including those from the risky groups” and establishment of Trust Points where young representatives of key population, including MSMs and sex workers, can get SRH services. Under Gender component UNFPA supported established eight victim support rooms within health facilities, mostly maternity houses, adoption of the “Guidance on strengthening of health sector response to gender based violence” and training on its use for SRH specialists. UNFPA also supported the so call Health Fairs when SRH and legal specialists visited remote villages and provided SRH and legal consultations to local women.

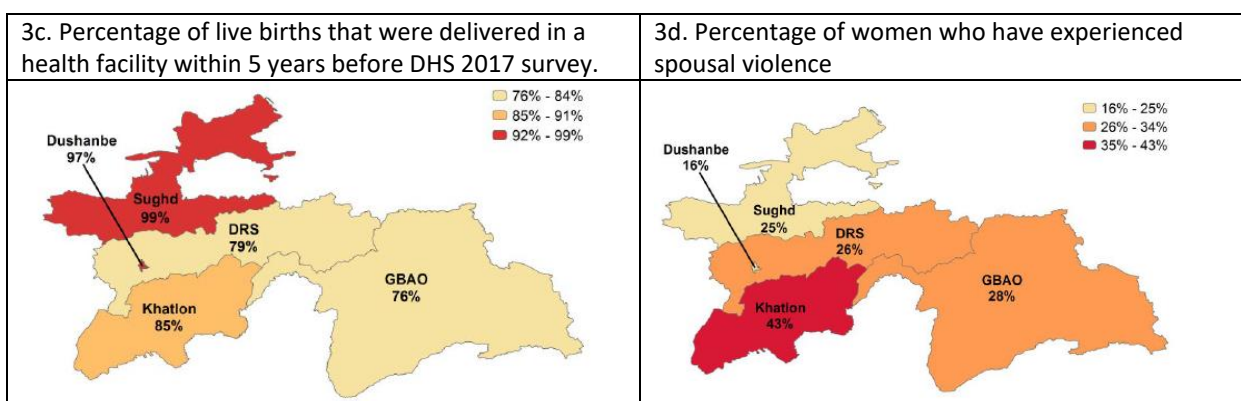
Sample

Selection of the sites for field visits were informed by the following criteria:

- Existence of institutions and individuals targeted by all UNFPA programme components;
- Volume of UNFPA assistance in terms of funding and capacity building;
- Coverage of activities implemented by direct execution (DEX) and national execution (NEX) modalities;
- Spatial differences in the situation with sexual and reproductive health and GBV (Fig. 3).

Figure 3. Spatial differences in modern contraceptive use, unmet need for family planning, percentage of live births that were delivered in a health facility, percentage of women who have experienced spousal violence.





Source: DHS 2017.

Many of the CP interventions targeted institutions and individuals in Khatlon and Sughd provinces. The sets of interventions implemented in the two provinces were similar, but these provinces are quite different, e.g. in terms of the use of modern contraceptives that is significantly higher in Sughd province compared to Khatlon province, or in terms of prevalence spousal violence that is higher in Khatlon province. So to understand how the CP interventions work in different contexts the evaluation team has decided to visit CP sites in both provinces.

Analysis of the CP documentations has also revealed that the SRH component was targeting all levels of the health care system - from national 3rd level maternity clinics that accumulate women with complicated pregnancies to rural health centers in remote rural settlements. To get a comprehensive understanding of the CP performance the evaluation has selected the site sample that reflected the full spectrum of different levels of health care institutions.

The resulting sample of CP sites included the national capital, capitals of Khatlon and Sughd provinces, several district centers in these two provinces as well as some rural locations (Table 2).

Table 2. Sample of the CP sites.

Province	District	Urban locations	Rural locations
		Dushanbe	
DRD	Rudaki	District center	
Khatlon	Kulyab	Kulyab	
		District center	Dehai Hakimov
	Kushoniyon	Bokhtar	
		Ismoili Somoni	Navkor
Sughd	Istaravshan	Khujand	
		Istaravshan	Obodi
	Bobojon Gafurov	Gafurov	
			Yova
			Rumon
	Spitamen	Spitamen	

The resulting sample of CP sites was illustrative, which is in line with the UNFPA Evaluation Handbook that indicates that “the evaluators should not aim to obtain a statistically representative sample, but rather an illustrative sample”.³

³ UNFPA (2019). Evaluation Handbook, page 62.

Data collection methods and sources of information

The evaluation team used the following data collection methods and sources of information:

- Review of the programme documentation and other relevant secondary data, including surveys and research papers;
- Individual and group semi-structured interviews with representatives of implementing and national partners to get their perspectives on changes due to the country programme interventions they are familiar with; relevance of the country programme to the national context; efficiency of the use of human, financial and technical resources allocated for the programme; quality of partnerships established by the UNFPA country office with the national partners; UNFPA added value;
- Individual and group semi-structured interviews with representatives of donor and international agencies to get their perspectives on UNFPA added value and used approaches;
- Individual and group semi-structured interviews with representatives other UN agencies to get their perspectives on UNFPA contribution to the UNCT and UNFPA added value;
- Individual semi-structured interviews with the staff of UNFPA country office;
- Individual semi-structured interviews with the teachers trained to deliver HLS courses to get their perspective on the usefulness of training, challenges they face when delivering the course, relevance of the course to the needs of the students;
- Group discussions with students who receive HLS courses to get their perspective on the course and their experiences with youth-friendly reproductive health services;
- Group discussions with SWs and MSMs reached by the programme to get their perspective on the relevance and added value of the programme;
- Individual interviews with women who were clients of the support rooms for victims of gender based violence (when they were available for interviews).

Overall the evaluation team reached 262 CP stakeholders (Table 3).

Table 3. Composition of the stakeholder sample.

Stakeholders	Adults		Adolescents & Youth	
	Male	Female	Male	Female
UN staff	7	3		
SRH	23	57		
Adolescents and Youth	12	35	18	42
Gender	4	20		
Population and Development	32	9		

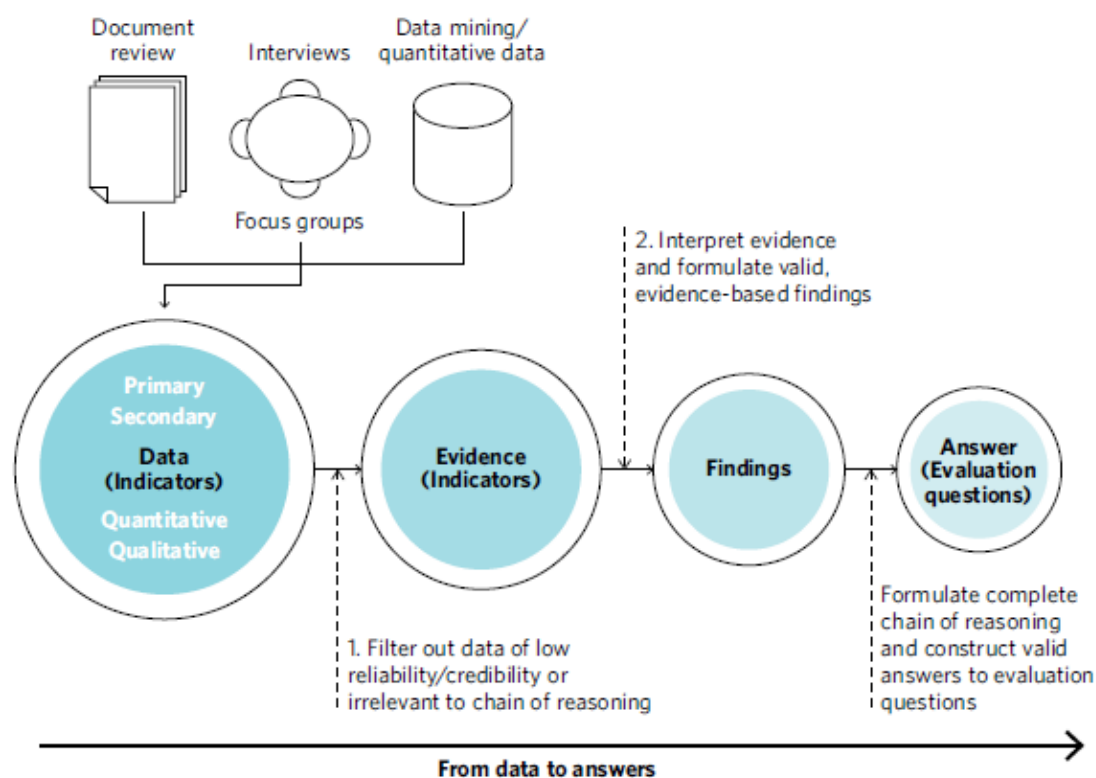
Data analysis

Analysis of the collected data was conducted in line with the recommendations provided in the UNFPA Evaluation Handbook (Fig. 4). Data analysis involved several stages. During the data collection stage members of the evaluation team held regular debriefing meetings that were used to compare and validate data from interviews and involved preliminary analysis of the topics and themes emerging from the data.

After the field phase was completed the evaluation team reviewed all collected data and triangulated data from different sources to identify findings and answers to evaluation questions.

Further analysis of the evaluation findings in consultation with the CO staff and members of the ERG informed evaluation conclusions and recommendations.

Figure 4. Data analysis process.



Source: UNFPA Evaluation Handbook (2019).

Human rights and gender considerations

The evaluation team has made a number of steps to integrate human rights and gender equality considerations in the evaluation design:

- Evaluation sample included both duty bearers (representatives of state institutions) and rights holders (including marginalized populations as well as NGOs representing right holders' groups);
- In most cases UNFPA country office and its implementing partners didn't have direct contact with end beneficiaries and the evaluation team had to rely on courtesy of specialists who participated in capacity building activities provided by the country programme to arrange meeting with end beneficiaries (e.g. teachers who were trained on HLS curricular were asked to invite their students to meet with the evaluation team, staff of NGOs involved in the implementation of the HIV-related activities were asked to help with arranging meetings with SWs and MSMs). To complement limited information about experiences of end beneficiaries (who are duty bearers) collected through interviews and focus groups, the evaluation team has identified a number of recent studies that looked into the use of SRH service and education and influence of cultural norms on this use, including:
 - Tajikistan Demographic and Health Survey (2017) conducted by the Agency on Statistics with support of USAID, UNICEF and UNFPA that includes information about SRH and gender based violence issues;
 - Adolescent Baseline Survey conducted by UNICEF in 2018-2019 that included questions about the use of youth-friendly SRH services and SRH education;

- Publication Nabieva, J., A. Souares (2019). Factors influencing decision to seek health care: a qualitative study among labour-migrants' wives in northern Tajikistan⁴ that discusses how existing cultural and family norms affect use of SRH services by women.
- Analysis and interpretation of the collected data was done from the perspective that individuals are subjects of rights and therefore entitled to assistance and with a focus on structural causes and their manifestations as recommended UNEG Guiding Document ““Integrating Human Rights and Gender Equality in Evaluation””.

Ethical considerations

In the process of this evaluation the evaluation team followed the UNEG Ethical Guidelines for Evaluation. Efforts to make the evaluation process ethical included the following measures:

- Evaluators always obtained informed consent of stakeholders prior to interview or focus group discussion. The purpose of evaluation, respondent's right to decline any of the questions and stop interview at any moment as well as measures that the team will take to protect his/her anonymity were explained to all respondents in the beginning of each interview/focus group.
- The evaluation report uses some stakeholder quotes as a way of giving voice to stakeholders and increasing the credibility of the findings but the evaluation team made sure that quotes cannot be attributed to specific individuals.
- The evaluation team will did not record names of interviewed under-age school students as well as names of sex workers and MSMs. Names of all other respondents presented in the Annex to this evaluation report were recorded and are included upon their informed permission.
- The evaluators tried to be open with the stakeholders about the limitations of their mandate and their ability to influence decisions about future UNFPA programming.

Methodology limitations and corresponding mitigation measures

This section presents challenges and limitations faced by the evaluation team in the course of this evaluation and mitigation measures taken to address them.

- **Loss of organizational memory as a result of staff mobility in the UN System**

A number of staff member of UNFPA team involved in implementation of the CP as well as staff members of other UN agencies who worked with UNFPA have left their positions by the time of this evaluation and in many cases were not available for interviews. To some extent the evaluation team was able to mitigate this challenge by arranging skype interviews with people who were based outside of the country and meetings with former UNFPA CO staff based in Tajikistan.

- **Limited access to final beneficiaries**

Due to intense travel schedule the evaluation team had to rely on support of local stakeholders (health professionals, teachers and NGOs) with arranging interviews with final beneficiaries of the CP. This approach worked well with SWs and MSMs because local NGOs established strong relations with them in the course of the CP implementations but proved challenging in terms of getting access to people using health care services. To some extent the evaluation team managed to mitigate this limitation, e.g. by asking teachers and students who were stakeholders of the Adolescents and Youth component about their experiences with the SRH services.

⁴ Retrieved from BMC Pregnancy and Childbirth
<https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-018-2166-6>

CHAPTER 2: Country context

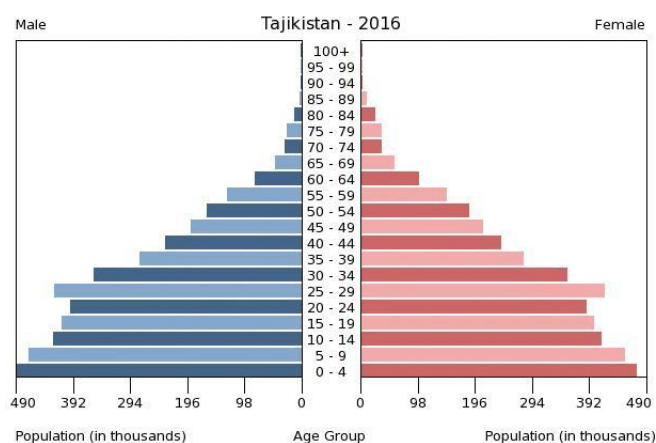
2.1 Development challenges and national strategies

Tajikistan is a small, landlocked, lower middle-income country located in Central Asia. GNI per capita of USD1,100 in 2016 made Tajikistan a lower middle-income country, but in 2018 Tajikistan made a step back a low-income country in a World Bank classification as a result of 2017 GNI per capita of USD990⁵. Tajikistan remains the poorest country of the Commonwealth of Independent States – 19.5 percent of the population lives on less than USD1.90 a day, and 56.6 percent lives on less than USD3.10 a day.⁶

Civil and political conflict that broke up shortly after Tajikistan independence in 1991 and persisted until 1997 caused widespread loss of life and physical damage. It also resulted in a significant exodus of human resources, mainly from industry and public administration, and a serious deterioration in the quality of human capital.

The population of Tajikistan is 8.9 million⁷. Almost 60 percent of the population is below age 24 and the average population age is 25.2 years (Fig. 5).

Figure 5. Population pyramid.



Source: IndexMundi, www.indexmundi.com/tajikistan/age_structure.html

Since 2000, Tajikistan has experienced high economic growth and significant poverty reduction. Between 2000 and 2017, GDP grew by more than 7 percent per year and poverty was reduced from above 80 percent to below 30 percent of the population. Still the country remains highly susceptible to external economic shocks and has suffered from recent regional economic downturns triggered by Russia's economic crisis, resulting in a 54 percent decrease in remittances from migrant laborers working abroad, from USD4.2 billion to USD1.9 billion between 2013 and 2016. Investment rates, and in particular private investment rates, have consistently been lower in Tajikistan than in other Central Asia and lower-middle income countries, which has further dampened growth and employment prospects.⁸

Human Development Index (HDI) that measures three basic dimensions of human development: a long and healthy life, access to knowledge and a decent standard of living increased from 0.550 in 2000 to 0.650 in 2017 putting the country in the medium human development category and positioning it at 127

⁵ <https://blogs.worldbank.org/opendata/new-country-classifications-income-level-2018-2019>

⁶ USAID: Tajikistan. www.usaid.gov/tajikistan/economic-growth-and-trade

⁷ UNDP (2018). Human Development Indices and Indicators: 2018 Statistical Update.

⁸ USAID: Tajikistan. www.usaid.gov/tajikistan/economic-growth-and-trade

out of 189 countries and territories.⁹ However Inequality-adjusted HDI is 0.562, which means a loss of 13.6 percent due to inequality in the distribution of the HDI dimension indices.

2017 value of a Gender Inequality Index (GII) was 0.317, ranking Tajikistan 69 out of 160 countries in the 2017 index. In Tajikistan, 20.0 percent of parliamentary seats are held by women, and 98.9 percent of adult women have reached at least a secondary level of education compared to 87.0 percent of their male counterparts. For every 100,000 live births, 32 women die from pregnancy related causes; and the adolescent birth rate is 36.4 births per 1,000 women of ages 15-19. Female participation in the labour market is 45.5 percent compared to 73.3 for men.¹⁰

Health

Tajikistan's health system is heavily centralized. Health services are provided overwhelmingly within the public sector, focusing historically on hospital-based curative care. The share of public health expenditure is only 2.3% of GDP (2019, MoHSP), among the lowest of countries in the Europe and Central Asia regional group.

Tajikistan government is committed to providing equitable access to essential health care services. The priority areas for improvement identified by the government are maternal and child health, reproductive health, noncommunicable diseases, malaria, tuberculosis, HIV/AIDS, and other sexually transmitted infections. Related recent reforms focus on strengthening the primary health care (PHC) system and restructuring the oversized hospital delivery network which was inherited from the Soviet period¹¹.

The government also prioritized (i) building managerial and financial capacity at PHC facilities; (ii) introduction of the Family Medicine model of practice; clinical capacity building of PHC physicians and nurses in FM; and (iii) rehabilitation and provision of medical equipment to PHC facilities¹².

Access to affordable health services is limited, especially to hospital and diagnostic services which are mostly not free. Public health care expenditures are modest at 2.0 percent of GDP, while private expenditures far exceed this amount at 4.9 percent of GDP (in 2014). About two-thirds of health expenditures are private, and most of them are out-of-pocket expenses. High levels of private out-of-pocket expenditures hurt poor families disproportionately and may also discourage households from seeking essential health care¹³.

Patient pathways differ in rural and urban areas. In rural areas, primary care is delivered through health houses, rural health centers and (to some degree) rural hospitals. In urban areas, primary care is delivered by district or city health centers. Many patients access higher levels of care directly without referral from the primary care level¹⁴.

Provision of SRH services is integrated into the primary health care system. Health houses serve as the first point of contact in rural areas. They are usually staffed with nurses and midwives. Health houses provide immunization, basic first aid, home visits, **basic antenatal care** and **family planning**, and medical referrals. In 2017 Tajikistan had 1719 health houses¹⁵.

⁹ UNDP (2018). Human Development Indices and Indicators: 2018 Statistical Update. Briefing note for countries on the 2018 Statistical Update: Tajikistan.

¹⁰ UNDP (2018). Human Development Indices and Indicators: 2018 Statistical Update. Briefing note for countries on the 2018 Statistical Update: Tajikistan.

¹¹ World Bank Group (2018). Tajikistan Systematic Country Diagnostic. Making the National Development Strategy 2030 a Success: Building the Foundation for Shared Prosperity.

¹² *ibid*

¹³ *ibid*

¹⁴ Khodjamurodov G, Sodiqova D, Akkazieva B, Rechel B. Tajikistan: health system review. *Health Systems in Transition*, 2016; 18(1):1–114.

¹⁵ Agency on Statistics under the President of the Republic of Tajikistan (2018). *Health Care in the Republic of Tajikistan*.

Health houses are subordinate to rural health centers, the next level of the health system in rural areas. (In 2017 Tajikistan had 831 rural health centers¹⁶.) Rural health centers are usually staffed by family doctors (and ob-gyns in some cases) as well as mid-level and junior health staff and provide the next level of primary health care. When there are no ob-gyns on staff, basic SRH services are provided by family doctors and midwives. Rural health centers are subordinate to district health centers and central district hospitals and offer diagnostics and basic treatment and minor surgeries.

In urban areas, primary and secondary care is delivered by district and city health centers. These are either free standing or associated with a hospital and offer preventive, diagnostic and rehabilitative services. Women reproductive health centers are part of district and city health centers. In 2017 there were 75 reproductive health centers¹⁷.

Maternity clinics are located at small rural hospitals, central district/city hospitals and provincial hospitals. Tajikistan has completed regionalization of its maternity clinic. Women with risks of complications are referred to 2nd and 3rd level clinics based in district and provincial centers.

The number of health care professionals involved in the provision of SRH services is growing (Table 4).

Table 4. Changes in the number of health professionals involved in provision of SRH services.

Category of specialists	2012	2015	2017
Family doctors	2141	2466	2517
Ob-gyns	1407	1569	1749
Midwives	4376	4712	5217

Source: Agency on Statistics under the President of the Republic of Tajikistan (2018). Health Care in the Republic of Tajikistan.

At the same time many women still have limited access to health care, including SRH services. During DHS 2017 survey more than 4 in 10 women (42%) reported facing problems in accessing health care for themselves. Getting money for advice or treatment was the most frequently mentioned problem (35%), followed by distance to a health facility (21%), not wanting to go alone (20%), and getting permission to go for treatment (18%)¹⁸.

HIV situation

Dominant mode of HIV transmission is sexual transmission. Epidemic remains concentrated among key populations (SWs and MSMs) and their sexual partners, including migrant male labourers working in the Russian Federation. Overall, the prevalence of HIV is still low, estimated at 0.3% in the adult population age 15-49 in 2016. The prevalence is higher in key populations: people who inject drugs (13.5%), sex workers (3.5%), and men who have sex with men (2.7%). Among the estimated 14,000 people living with HIV in Tajikistan in 2016, only 30% were accessing antiretroviral therapy. The incidence of HIV in Tajikistan has been rising; between 2010 and 2016, new HIV infections increased by 23%¹⁹.

SRH services including friendly services are provided to young people and key populations, especially sex workers in SRH centres, which are funded by the government. The centres provide a wide range of services including syndromic approach to STI cases management and rapid (strip-based) HIV testing. The clients are referred to AIDS Centres for ELISA testing upon a positive rapid test. SRH Centres and HIV Centres undertake testing of pregnant women and manage PMTCT (vertical transmission) programmes. The National clinical protocol requires all pregnant women living with HIV to take antiretroviral medication. All new born babies born to women living with HIV receive liquid AZT for 6 weeks; the

¹⁶ Agency on Statistics under the President of the Republic of Tajikistan (2018). Health Care in the Republic of Tajikistan.

¹⁷ Agency on Statistics under the President of the Republic of Tajikistan (2018). Health Care in the Republic of Tajikistan.

¹⁸ DHS 2017.

¹⁹ DHS 2017.

mothers are not required to remain on antiretroviral medication. Health care workers do not support breast-feeding.

The demand of sexual and reproductive health services by key populations is low according to communities and health care providers with less than 10% of the sex workers accessing SRH services. STI specialists are accessible to key populations free of charge provided that sex workers and men who have sex with men are referred from Trust Points. Those who do not access Trust Points do not receive services for free. Sex workers in some locations have access to free gynaecological services and in some locations men who have sex with men have access to a proctologist. The costs of laboratory tests and medicines are borne by the clients of the services; sometimes this is prohibitive and there is loss to follow up as a result. Sex workers receive certain STI treatment free of charge where those medicines have been purchased through the Global Fund grant and are available in reproductive health centres. The same entitlement does not exist for men who have sex with men, including those who sell sex. The demand of STI screening is not high among sex workers or men who have sex with men and most do not visit physicians, with cost being one factor and stigma being another. The costs of STI screening are generally too high for key populations to afford. In addition, many physicians lack training in STI diagnostics, particularly gonorrhoea, chlamydia and genital mycoplasma.

Integrating HIV and SRHR (and TB) within primary health care settings is an important component of programming at the country level. This includes a focus on key populations. Increased attention is required to address migrant men returning from labour migration to the Russian Federation. Given the high proportion of men from Tajikistan going to the Russian Federation for work, the generalised HIV epidemic in the Russian Federation, the lack of coverage of programming for sex workers in the Russian Federation, the absence of harm reduction programmes for people who inject drugs, and punitive approaches to men who have sex with men, it is inevitable that migrant men will face increased risk and vulnerability to HIV. The lack of HIV and STI programmes in the home communities of returning men further increases the likelihood of an expanding HIV epidemic among migrant men and their sexual partners – including women as wives and girlfriends who would not perceive themselves at risk of or vulnerable to, HIV and STI infections.

Knowledge of HIV or AIDS among women in Tajikistan continues to be low. According to DHS 2017 only about half of women age 15-49 (53%) are aware of HIV or AIDS. 38% of women know that using condoms is a way to prevent HIV transmission, and 43% recognize that the risk of getting HIV can be reduced by limiting sexual intercourse to one uninfected partner. Just over one-third of women (36%) are aware of both of these prevention methods.

Women age 15-19 are less likely to know that HIV can be prevented by using condoms and limiting sexual intercourse to one uninfected partner (19%) and to have comprehensive knowledge of HIV (9%) than women aged 20-49²⁰.

Youth

Tajikistan has a very young population, but economic opportunities, livelihoods options and public participation for young people in Tajikistan are limited. Youth unemployment remains high, at about 20% in 2018²¹ and this is a key social determinant of health, with resulting implications for physical and mental health, in particular. Level of knowledge on HIV/STI is still low despite efforts and investments of international community especially in rural areas. Tajikistan is faced with a young and rapidly growing population with 55 percent of the population in Tajikistan is under the age of 25. Tajikistan has a working age population, defined as 15-64-year old, of about 4.06 million people who can contribute productively to the economy. Youth (15-24-year old) have weaker jobs outcomes. Youth who are idle,

²⁰ DHS 2017.

²¹ World Bank, Youth Unemployment Rate for Tajikistan [SLUEM1524ZSTJK], retrieved from FRED, Federal Reserve Bank of St. Louis; <https://fred.stlouisfed.org/series/SLUEM1524ZSTJK>, August 12, 2019.

i.e. youth who are neither employed nor in school (NEET), represent 40 percent of the total, or 1.8 million young people, which is high by international standards²². Public services to the youth, especially higher education and sexual and reproductive health services, are poor and are not always accessible. The associated feelings of frustration can drive young people to activities that are detrimental to their own future and that undermine stability and development in the country more generally. During the period from 2016 to 2019, the National Youth Social Development Program for the years of 2016-2018 was adopted. The State Strategy on Youth adopted in 2011 is currently ongoing and will last until 2020.²³

Gender

As regards gender equality, major progress has been made over the last two decades, but disparities persist and women and girls remain discriminated against in health and education, at the workplace and in public and political life, with negative consequences for their prospects in life and that of entire societies.

The Government of Tajikistan is steadily working on the policies and laws to enhance the country's human rights agenda. In July 2014, the country acceded to the Optional Protocol to the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), ratified in 1993. The Law on the Prevention of Violence in the Family and the associated State Programme are the most recent milestones in the adopted comprehensive legislative framework to promote gender equality and fight discrimination against girls and women.

A gender network on mainstreaming gender approaches into the work of ministries and departments has been established. In order to ensure women's rights, a number of Government laws and decrees have been adopted, in particular, the State programme on the education, selection and placement of talented girls and women in leadership posts in the Republic of Tajikistan in 2017–2022, of 1 April 2017, the national strategy on promoting the role of women in the Republic of Tajikistan for the period 2011–2020, of 29 May 2010, and the plan of action of the national strategy on promoting the role of women in the Republic of Tajikistan for the period 2015–2020, of 29 August 2015. The Government adopted the State programme for the prevention of domestic violence in the Republic of Tajikistan for the period 2014–2023. The strategic goal of this programme is to ensure the effective implementation of the mechanisms for the prevention of domestic violence with the participation of all State entities and the public, significantly improve the crime control system, ensure effective protection of civil rights and freedoms, protect constitutional norms, ensure family stability and prevent domestic violence.²⁴

Whilst formal equality and anti-discrimination is guaranteed by law, actual implementation is faced with a number of impediments, such as lack of capacities; uneven commitment of public and private stakeholders; considerable under-financing of programmes and action plans to address discrimination; the patriarchal and traditional structure of the society, political developments and the overall socio-economic situation that further undermines anti-discrimination measures. Family violence, and exploitation against women and girls is socially accepted and widespread. Gender based violence (GBV) is linked with health-related problems, since it has indisputable consequences and serious implications for current and future health (for example, pregnancy and delivery, HIV and related issues). In this context, women's low awareness of their rights and issues pertaining to residency registration and the rise of early, polygamous and unregistered marriages further aggravate their vulnerability. Estimates on the prevalence of domestic violence as a form of GBV range from one-third to one-half of women in Tajikistan having regularly experienced physical, psychological, or sexual violence.²⁵ According to the 2017 DHS among the ever-married women (ages 15–49), 31% have experienced physical, sexual, or

²² Victoria Strokova and Mohamed Ihsan Ajwad. 2017. "Tajikistan Jobs Diagnostic: Strategic Framework for Jobs." World Bank, Washington, DC. License: Creative Commons Attribution CC BY 3.0 IGO.

²³ Committee on youth and sport <http://youth.tj/ru/regulations/youth/>

²⁴ Committee on the Elimination of Discrimination against Women
Sixth periodic report submitted by Tajikistan under article 18 of the Convention, due in 2017

²⁵ Violence is Not Just a Family Affair. Women Face Abuse in Tajikistan, p. 13.

emotional violence by their current or most recent husband. The prevalence of spousal violence has increased by 7 percentage points in the 5 years since the 2012 DHS. One in 10 women sought help to stop the violence they had experienced. Three in four women neither sought help nor told anyone about the violence.²⁶

At the same time, human trafficking as another form of GBV both inside and outside Tajikistan is increasing. According to the 2019 Trafficking in Persons Report of the US Department of State, Tajikistan has been placed on tier 2 watch list. This classification means that Government of Tajikistan does not fully meet the minimum standards for the elimination of trafficking; however, it is making significant efforts to do so. During the past years, the government efforts in the area of combatting human trafficking included amendment of the criminal code to eliminate inconsistencies with the 2014 victim protection law, facilitation of the return of Tajik children from Iraq and Syria; and collaborating with local and international civil society groups on the development and review of trafficking laws and the draft 2019-2021 national action plan. The government mandated a national referral mechanism in 2016. In 2018, a legislative reform working group, which included representatives from the justice sector, law enforcement, Presidential Administration, parliament, and civil society, developed draft guidelines for victim identification, which it submitted to the government for approval.²⁷

Population and development

National statistical system includes the Agency on Statistics under the President of the Republic of Tajikistan (AS) and its territorial and other subordinated bodies, as well as a number of statistical departments of national ministries and agencies that are considered as producers of official statistics, e.g. Ministry of Health and its Republican Centre for Medical Statistics and Information and Office of Vital Registration under the Ministry of Justice.²⁸ Operation of the system is regulated by the Law on State Statistics, № 588, adopted in 2010.

The AS prepares annual programmes of statistical work that are then adopted by the government. The national programme is converted also into annual programmes of statistical works for each territorial office (district, province, or city). Most of the items contained as reporting obligations in the national programme appear also in the regional or sub-regional programmes, if the data flow involves the territorial level concerned. There are also long-term programmes of development of statistics, the current one covers the period 2016-2021.

In 2011, Tajikistan requested the United Nations Economic Commission for Europe (UNECE) to conduct the assessment of the national statistics system in Tajikistan that was entitled 'Global Assessment of the National System of Official Statistics of the Republic of Tajikistan' (GA). The GA was conducted in 2012 and it identified the following critical issues to be addressed in the statistical system of Tajikistan: (i) weak institutional capacity and inefficient organizational structure of the statistical system, (ii) ineffective institutional coordination between various statistical agencies and the AS, (iii) lack of well-developed human resources framework, (iv) inadequate analytical capability and qualifications of personnel of the statistical system, (v) weak statistical infrastructure, and (vi) poor physical and information technology infrastructure.²⁹

The long-term social-economic programs - the two National Development Strategies of 2006-2015 and of 2016 – 2030 and the Poverty Reduction Strategies of the Republic of Tajikistan (PRS) - stressed the importance of obtaining relevant and reliable statistical data to make decisions for successful program implementation, and demand was not simply for better statistics, but to expand the capacity to analyze and interpret statistics in support of evidence-based policy making and implementation monitoring. Development of the national statistical system is supported by the World Bank and UN agencies.

²⁶ Tajikistan DHS 2017

²⁷ <https://www.state.gov/reports/2019-trafficking-in-persons-report-2/tajikistan/>

²⁸ Global Assessment Report: National System of Official Statistics of the Republic of Tajikistan (2013).

²⁹ World Bank (2018). Report on the Implementation of the NSDS (P145185).

In 2014 recognizing the challenges of the current civil registration system and their impact on the most vulnerable and at-risk population, especially women, children and persons with disabilities, the Government adopted the Civil Registry Offices (ZAGS) Development Programme (2014-2019).

2.2: Country situation in the context of three UNFPA transformative results

According to UNFPA strategic plan 2018-2021 in the period leading up to 2030 UNFPA organizes its work around three transformative and people-centred results: (a) an end to preventable maternal deaths; (b) an end to the unmet need for family planning; and (c) an end to gender-based violence and all harmful practices, including female genital mutilation and child, early and forced marriage. This section describes the situation in Tajikistan in relation to these three transformative results.

End to preventable maternal deaths

National statistical data as well as UN estimates based on mathematic modelling³⁰ indicate progressive decline in the maternal mortality ratio (MMR) in Tajikistan (Table 5). The national MMR value for 2017 is 24.1³¹, UN estimate for 2017 is 17³². Hemorrhages and pregnancy toxocosis remain among key reasons of obstetric maternal mortality³³.

Table 5. Tajikistan: trends in maternal mortality (2005 – 2015).

Indicator	2005	2010	2015
Maternal mortality ratio (maternal deaths per 100 000 live births – 2015 model estimate)*	46	35	32
Maternal mortality ratio (maternal deaths per 100 000 live births – 2019 model estimate)**	32	23	18
Maternal mortality ratio (maternal deaths per 100 000 live births – national data)***	43.4	45.0	28.4

*Source: WHO et al (2015). Trends in maternal mortality: 1990 to 2015. Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.

**Source: WHO et al (2019). Trends in maternal mortality: 1990 to 2015. Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Executive Summary.

***Source: Tajikistan Voluntary National Review (2017).

Progress in the area of maternal mortality is backed by improvement in women access to maternal health care. For example, the share of women age 15-49 who received any antenatal care (ANC) from a skilled provider increased from 79% in 2012 to 92% in 2017³⁴. Still even in 2017 only 64% of pregnant women had four and more ANC visits and only 67% had ANC visits in the first trimester of pregnancy. Percentage of deliveries in health facilities also increased: from 77% in 2012 to 88% in 2017, and the percentage of home deliveries fell from 23% in 2012 to 12% in 2017. The proportion of births assisted by a skilled provider has also increased: from 87% in 2012 to 95% in 2017 and the percentage of births assisted by doctors increased from 64% in 2012 to 83% in 2017³⁵.

³⁰ WHO (2015). Trends in maternal mortality: 1990 to 2015. Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.

³¹ Government of Tajikistan (2018). National Report on Implementation of Strategic Documents of the Country in the context of the Sustainable Development Goals.

³² WHO et al (2019). Trends in maternal mortality: 1990 to 2015. Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Executive Summary.

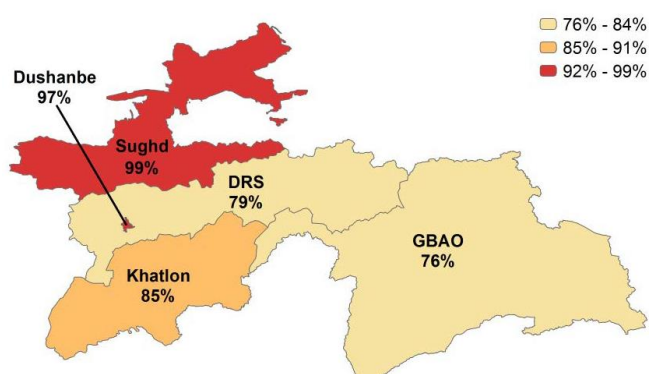
³³ Национальный обзор Республики Таджикистан по осуществлению Пекинской декларации и Платформы действий (1995 года) и итоговых документов двадцать третьей специальной сессии Генеральной Ассамблеи (2000 года) в контексте двадцатой годовщины четверной Всемирной конференции по положению женщин и принятия Пекинской Декларации и Платформы действий в 2015 году.

³⁴ DHS 2017.

³⁵ *ibid.*

At the same time there are still disparities between the regions in terms of share of deliveries in health facilities: while in Dushanbe and Sughd province almost all births take place in a health facility, the share of births delivered in health facilities in DRS and GBAO are below 80% (Fig. 6).

Figure 6. Percentage of live births in the 5 years before the DHS 2017 that were delivered in a health facility.



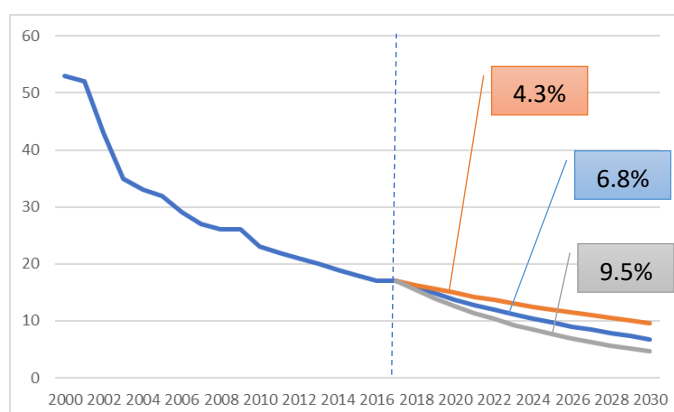
Source: DHS 2017.

Another concern is that the prevalence of complications during pregnancy, delivery and post-natal period is on the rise: from 3156.7 cases per 100,000 women in 2012 to 4455.1 cases in 2017³⁶. The key reasons for complications are anemia (397.1 cases per 1000 births) and late toxicosis (48.5 cases per 1000 births)³⁷.

According to the Framework of Actions for the follow-up to the Programme of Action of the ICPD Beyond 2014, "ninety percent of maternal deaths are preventable, and the elimination of all preventable deaths requires a well-functioning and integrated primary health-care system that is close to where women live; effective referral mechanisms to respond to complications of pregnancy and delivery; and the availability and accessibility of functioning basic and comprehensive emergency obstetric care".

According to recent UN estimates, in 2000-2017 an average annual rate of MMR reduction was 6.8% (80% confidence interval is 4.3% to 9.5%)³⁸. If this rate of MMR reduction continues till 2030, the MMR will go down to 7 (5-10) (Fig. 7).

Figure 7. MMR: UN estimates (2000-2017) and projections till 2030.



³⁶ Agency on Statistics under the President of the Republic of Tajikistan (2018). Health Care in Republic of Tajikistan.

³⁷ Ibid

³⁸ Maternal mortality in 2000-2017. Internationally comparable MMR estimates by the Maternal Mortality Estimation Inter-Agency Group (MMEIG) WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Tajikistan.

Literature review conducted by the evaluation team indicates that in Tajikistan cultural norms also play important role in women access to health care during pregnancy. For example, a recent study of health seeking behavior of rural women in northern Tajikistan with specific focus on antenatal and obstetric complications as a result of delayed access to health services has found that while all women reached by this study delivered their children in health care facilities, crucial decisions about delivery such as when to seek obstetric services and whether and how long to stay in a facility were taken by mothers-in-law³⁹. The study has also found a clear pattern between family support in receiving antenatal care and the age of the mother-in-law: those aged around 50 and younger encouraged their daughters’-in-law to make regular antenatal visits; mothers-in-law of the older generation saw antenatal care as unnecessary and, in some cases, as harmful to the fetus.

This above data suggests that putting an end to all preventable maternal deaths in Tajikistan will require not just further improvement of the health care system, but also addressing the existing cultural norms.

End to the unmet need for family planning

The reproductive health and family planning services are still not fully integrated into the primary health care system. Young women are limited in making decision related to reproductive health and family planning being under the pressure of husband or his relatives⁴⁰.

While 98% of married women aged 15-49 know at least one method of family planning, proportion of women with unmet need for family planning remains steady (Table 6) which suggests that by 2030 Tajikistan won’t achieve the UNFPA target to end all unmet need for family planning.

Table 6. Tajikistan: met and unmet needs for family planning.

Indicator	2012*	2017*	2019**
Proportion of women of reproductive age (aged 15–49 years) with unmet need for family planning	23	23	21
Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied	55	56	63
Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods	51	52	58

Sources: *DHS 2017; **UNFPA. State of World Population 2019.

Use of contraceptives is highest among married women with three to four children (38%). Majority of women wait to begin using contraception until they have one child: less than 1% of married women with no children are using modern contraception. Use of modern contraception is higher in urban areas (32% compared to 26% in rural areas). Higher use of modern contraception is also associated with higher education (19.8% among women with no education or a primary education compared to 31.7% among women with a higher education) and higher income level (25.5 among women in the lowest wealth quintile to 30.8% among women in the highest quintile)⁴¹.

End to gender-based violence and all harmful practices

In 2013 Tajikistan enacted the Law on the Prevention of Domestic Violence and amended the Code of Administrative Offences to include articles specifying liability for violation of the requirements of this legislation and for any violation of a restraining order. In 2014 the government launched the State Programme for the Prevention of Domestic Violence 2014-2023. Still Law on the Prevention of Domestic

³⁹ Nabieva, J., A. Soares (2019). Factors influencing decision to seek health care: a qualitative study among labour-migrants’ wives in northern Tajikistan.

⁴⁰ Government of Tajikistan (2018). National Report on Implementation of Strategic Documents of the Country in the context of the Sustainable Development Goals.

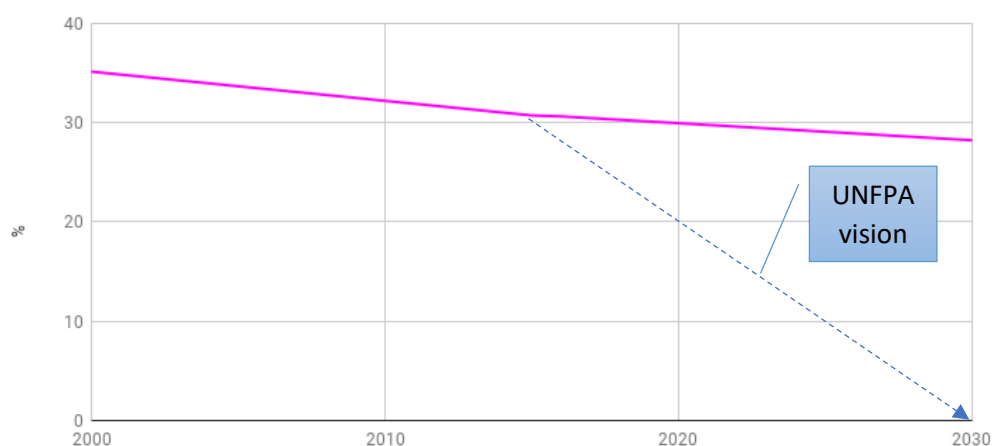
⁴¹ DHS 2017.

Violence does not include strong enforcement measures and does not contain a concept of direct and indirect discrimination in public and private life⁴².

According to DHS 2017, 24% of women age 15-49 have experienced physical violence since age 15, and 17% experienced physical violence in the 12 months preceding the survey. Two percent of women have experienced sexual violence. 31% of ever-married women have experienced physical, sexual, or emotional violence by their current or most recent husband. The prevalence of spousal violence has increased by 7 percentage points in the 5 years since the 2012 survey.

Modelled projections of the prevalence of physical or sexual violence against women suggest that Tajikistan won't reach the UNFPA target to end gender-based violence by 2030 (Fig. 8).

Figure 8. Share of women age 15+ who experienced physical or sexual violence by an intimate partner in the last 12 months: modelled for 2000-2030.



Source: Supplement to: GBD 2016 SDG Collaborators. Measuring progress and projecting attainment on the basis of past trends of the health-related Sustainable Development Goals in 188 countries: an analysis from the Global Burden of Disease Study 2016. Lancet 2017; published online Sept 12.

The women vulnerability persists mainly due to a low level of education, limited access to economic resources, a misconception of the traditional family structure and the existence of gender stereotypes in the public consciousness⁴³.

2.3: Country situation in the context of relevant SDGs and targets and government plan to achieve SDGs

SDGs implementation in Tajikistan is operationalized through the National Development Strategy till 2030 (NDS-2030) and three five-year medium-term development programs. NDS-2030 aims to improve the living standards and welfare of the population. It uses the "Concept 4+1" to define the structure of the strategic goals and priorities. It includes four strategic development goals that are fully aligned with the SDGs:

- Ensure energy security and efficient use of electricity (SDG 7);
- Exit from communication dead-lock and turn country into a transit path (SDG 9);
- Ensure food security and people's access to good quality nutrition (SDG 1 and SDG 2);
- Expand productive employment (SDG 8).

It also emphasizes the need for enhanced human capital development that includes education, public health, social protection and gender equality.

⁴² Government of Tajikistan (2018). National Report on Implementation of Strategic Documents of the Country in the context of the Sustainable Development Goals.

⁴³ Government of Tajikistan (2018). National Report on Implementation of Strategic Documents of the Country in the context of the Sustainable Development Goals.

Mid-term Development Program of the Republic of Tajikistan for 2016-2020 (MTDP 2020) sets forth the main activities for achieving the first phase of the implementation of the NDS-2030 and the SDGs. MTDP 2020 focuses on:

- Ensuring energy security and access to energy sources.
- Balanced and integrated development of the regions (territories) of the country. Results of the MDGs implementation were concentrated mainly in the capital. Implementation of SDGs requires a more even distribution of development benefits.
- Gender equality is the target indicator in the NDS-2030 and is one of the cross-sectional development priorities in the MTDP 2020. Prevention of all forms of violence against women and girls is one of the sub-priorities of the NDS-2030.
- Making young people an integral part of the development, implementation and evaluation of plans and strategies that affect their lives. Significance of this issue is highlighted both in the NDS-2030 and the MTDP-2020.

The NDS-2030 envisions a significant improvement of the situation in the area of gender equality through:

- Improving the legislation on gender equality;
- Developing institutional mechanisms for integrating national and international commitments in the area of gender equality and women's empowerment for institutional policies;
- Improving the mechanisms for ensuring legal literacy and social participation of women, including rural women;
- Improving gender potential and gender sensitivity of civil servants; and
- Implementing gender-responsive budgeting practices.

As one of the measures to advance human capital development the government has adopted an Action Plan on sexual and reproductive health of mothers, newborns, children and adolescents within the framework of the National Health Strategy of the Republic of Tajikistan for the period 2016-2020. All pregnant women have access to day-care services at the PHC level during a day and access to primary-level hospitals (Central District Hospital) at the nighttime. In addition, the procedure for referral of pregnant women to the second and third levels was developed.

In 2015 the government enacted provision of reproductive health counseling for under-age youth, including those from at-risk groups. There are 21 Medical Advisory Departments for young people that were established on the basis of Centers of Reproductive Health⁴⁴.

The Rapid Integrated Assessment of national-level strategies and sectoral programs and plans conducted in 2016 has found that NDS-2030 and MTDP 2020 incorporate about 64% of the SDG targets are reflected in two national strategic documents of the country. When another eight sectoral strategies are taken into account, mainstreaming of SDGs in these documents is 78%⁴⁵.

Targets related to SDGs 3 (Health), 4 (Education) and 5 (Gender Equality) that are within UNFPA mandate are fully incorporated into the Tajikistan national strategies.

⁴⁴ Government of Tajikistan (2018). National Report on Implementation of Strategic Documents of the Country in the context of the Sustainable Development Goals.

⁴⁵ Tajikistan VNR 2017.

CHAPTER 3: United Nations/UNFPA response and programme strategies

This section presents a brief description of the evaluated UNFPA country programme for Tajikistan 2016-2020, including its relation to the previous country programme, design of the current programme and its key financial parameters.

3.1 UNFPA response through the country programme

3.1.1 Brief description of UNFPA previous cycle strategy, goals and achievements

The previous UNFPA country programme for Tajikistan focused on reproductive health and rights, gender equality, and population and development. It established several strategic partnerships with the Government, United Nations organizations, development partners, and civil society. UNFPA relied on national execution to enhance national ownership and coherence.

Key achievement of the 2010-2015 country programme included: (a) setting up of an emergency obstetrics care system and decreased maternal mortality; (b) increased availability and access to modern contraceptives; (c) international recognition of the 2010 census; (d) emphasis on demographics in the national strategy for improving living standards; and (e) laying of important foundations for an integrated response to gender based violence; (f) helped to increase the number of young men and women who are able to identify ways to prevent and who reject misconceptions about HIV transmission.

The evaluation of the previous programme found that (a) coordination and partnerships within and across varying constituencies had helped to increase focus on the multifaceted UNFPA agenda; (b) evidence and data had helped to inform policies and facilitate implementation (the 2010 census met international standards and the population dynamics chapter was included in the last national living standards improvement strategy, 2013); and (c) networks made voices of affected populations stronger and allowed for better outreach and service provision for thousands of sex workers and men having sex with men.

3.1.2 Current UNFPA country programme

The UNFPA country programme for Tajikistan 2016-2020 formulated through stakeholder consultations under the leadership of the Government of Tajikistan is grounded in the principles of the International Conference on Population and Development (ICPD). The programme responds to national priorities and contributes to the United Nations Development Assistance Framework (UNDAF) for Tajikistan 2016-2020, particularly in the areas of governance, health, youth and gender.

The design of the current country programme was informed by UNFPA strategic plan 2014-2017 and recommendation of the evaluation of the previous programme, including: (a) focus on four programmatic areas of the UNFPA strategic plan, 2014 2017; (b) give a higher profile to UNFPA work with and for young people; (c) use the post 2015 development agenda and human rights treaties and obligations as the overarching international reference frameworks; (d) focus on reducing inequities in gender relations and access to sexual and reproductive health services in rural areas; (e) increase preparedness for and engagement in humanitarian settings in all programmatic areas; and (f) build national capacities, increase investments in advocacy and policy dialogue and identify ways to reduce service delivery. As a result the current country programme has a stronger focus on adolescents and youth and gender equality as well as strengthening national policies (Table 7).

Table 7. Evolution of the UNFPA response through the country programme in Tajikistan.

CP 2010-2015 outcomes	CP 2016-2020 outcomes
Reproductive health and rights: <ul style="list-style-type: none">• The health system is strengthened	Sexual and reproductive health: <ul style="list-style-type: none">• Increased availability and use of integrated sexual and reproductive health services, including family

<ul style="list-style-type: none"> Among the most vulnerable persons, there is greater access to and use of high-quality reproductive health services, including services to prevent sexually transmitted infections and HIV and AIDS 	<p>planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access</p>
	<p>Adolescents and youth:</p> <ul style="list-style-type: none"> Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health
<p>Gender equality:</p> <ul style="list-style-type: none"> Improved coverage of high quality social services and assistance among vulnerable groups, particularly women and refugees 	<p>Gender equality and women’s empowerment:</p> <ul style="list-style-type: none"> Advanced gender equality, women’s and girls’ empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth
<p>Population and development:</p> <ul style="list-style-type: none"> National and local levels of government have the capacity, including accurate information, to implement democratic governance practices grounded in international standards and law, and to effectively and strategically plan, finance and implement development initiatives in an inclusive and participatory manner 	<p>Population dynamics:</p> <ul style="list-style-type: none"> Strengthened national policies and international development agendas through integration of evidence based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality

Focus areas

● Sexual and reproductive health

Interventions supported in this area contribute towards achievement of two outputs: (1) Increased capacities of institutions to deliver integrated sexual and reproductive health services by strengthened evidence based policy frameworks and institutional mechanisms, and (2) Strengthened national capacity to develop and regularly update contingency plans that address the sexual and reproductive health needs of women, adolescents and youth in crisis situations. Eventually these interventions shall contribute towards two of three UNFPA transformative results: (1) end to preventable maternal deaths, and (2) end to unmet need for family planning.

UNFPA support in this area was structured around three sub-areas: maternity health, family planning and HIV prevention. In the **maternity health** sub-area, UNFPA supported (a) development of national legal and strategic documents; (b) implementation of the WHO effective perinatal care principles and technologies at national, regional and district level maternity clinics and into the pre-service and post-diploma curricular at national medical education institutions; (c) strengthening of the national emergency obstetric care system; (d) development of the maternal death surveillance and response system, including implementation of the near miss cases review; (e) introduction of cervical cancer screening in two pilot districts; (g) review and improvement of the provision of gender-sensitive integrated SRH services by primary health care facilities; (g) review and reform of the midwifery education.

In the **family planning** sub-area UNFPA supported (a) advocacy to the government to establish state budget for RH commodities and transition to taking over procurement of contraceptives; (b) building capacity of staff of the reproductive health service delivery points; (c) monitoring of availability of

contraceptives at the reproductive health service delivery points; (d) development of national and regional humanitarian contingency plans with integrated SRH provisions.

In the **HIV-prevention** sub-area UNFPA supported (a) building capacity of national institutions to provide client-tailored, integrated sexual and reproductive health services for youth and key populations; (b) build capacities of networks and organizations managed by youth, key populations and other specific groups to meaningfully participate in planning and implementation of programmes that address their needs and vulnerabilities; (c) public awareness of and support for sexual and reproductive health and rights and the needs of key populations.

- **Adolescents and youth**

Under this focus area UNFPA works towards two outputs: (1) Increased capacity of national institutions and networks to conduct evidence based advocacy for incorporating adolescents and youth rights in national laws, policies and programmes; (2) Increased participation of civil society organizations in promoting sexual and reproductive health and rights of vulnerable and marginalized youth groups.

Within this focus area UNFPA work is structured around the following directions: (a) support to youth networks (YPEER, YSAFE, UNESCO Club volunteers), (b) support to introduction of the healthy life style (HLS) education to secondary schools through development and institutionalization of HLS curriculum and direct training of school teachers to deliver this curriculum.

- **Gender equality and women's empowerment**

Interventions supported in this area contribute towards achievement of one output: Strengthened capacity of institutions to enable delivery of multisectoral services and to address gender based violence and discrimination in line with international human rights treaties obligations. They also contribute towards one of the three UNFPA transformative results: End to gender-based violence and all harmful practices, including female genital mutilation and child, early and forced marriage.

Within this focus area UNFPA supported (a) development of national legal and strategic documents; (b) building capacity of health specialists to provide right based gender sensitive SRH services to victims of gender based violence; (c) strengthening of support rooms for victims of gender based violence within health facilities; (d) establishment of the intersectoral response to gender-based violence system, including essential service packages and standard operating procedures (SOPs) for health, police and psycho-social sectors with relevant state agencies; (e) engagement of government partners and NGOs in preparation of the national CEDAW implementation and reporting; (f) engagement of national stakeholders, including members of parliament, men and boys, and religious leaders in promotion of gender equality; (g) Public Health Fairs – bringing qualified health care professionals and legal experts from the capital to remote villages to offer screening and consultations on reproductive health and rights and legal issues to women in rural areas and establish community of educated clients to promote their rights to social and economic services and prevent GBV against women and girls.

- **Population dynamics**

Interventions supported in this area contribute towards achievement of one output: Strengthened national capacity to produce evidence and to formulate national policies and strategies that integrate population issues.

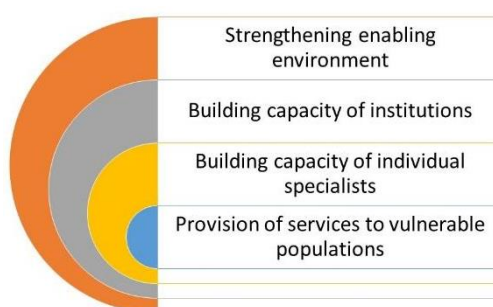
Within this focus area UNFPA supported (a) national population surveys and studies; (b) integration of population data in national policies and strategies; (c) development of the national capacity in preparation to 2020 census through training events and study tours, and (d) reform of the Civil Registration System.

Types of interventions supported within the framework of the country programme

Types on interventions supported by UNFPA within the framework of the current country programme ranges from support to strengthening on national enabling environment though development of legislation, policies and strategies to building capacity of individual institutions, e.g. through

development and introduction of clinical protocols in health care facilities, to building capacity of individual specialists and to direct provision of services to vulnerable and marginalized populations (Fig. 9).

Figure 9. Types of interventions supported by UNFPA country programme.



Vulnerable and marginalized groups directly reached by the country programme activities include sex workers and MSMs, victims of gender based violence, and women in remote hard to reach villages.

The country programme worked both with duty-bearers, e.g. government executives and members of parliament, and rights holders, including NGOs, young people and vulnerable and marginalized population. Under the adolescents and youth focus are the programme has an explicit focus on building capacity of national civil society networks to conduct evidence based advocacy for incorporating adolescents and youth rights in national laws, policies and programmes and on greater participation of civil society organizations in promoting sexual and reproductive health and rights of vulnerable and marginalized youth groups. The gender equality component has a strong focus on building capacity of duty bearers to implement their obligations under international human rights treaties, including CEDAW.

Geographic coverage

Majority of activities implemented within the framework of the current country programme were implemented in the national capital Dushanbe, Sugdh region and its center the city of Khujand, Khatlon region and its center the city of Bokhtar (former Kurgan-Tyube) and DRS, mainly Rasht Valley.

3.2 The financial structure of the country programme

Majority of the country programme budget is allocated for interventions in the area of sexual and reproductive health (Table 8). The second largest area is population dynamics. About two thirds of financial resources were expected to come from UNFPA regular resources, and the remaining amount was to be raised from other sources.

Table 8. Planned allocation of resources, (Million USD).

Focus area	Regular resources	Other resources	Total
Sexual and reproductive health	3.0	1.0	4.0
Adolescents and youth	0.4	0.2	0.6
Gender equality and women's empowerment	0.5	0.2	0.7
Population dynamics	0.7	0.8	1.5
Programme coordination and assistance	0.4	0	0.4
Total	5.0	2.2	7.2

Source: CPD for Tajikistan 2016-2020.

By mid-2019 the CP expenditure amounted to almost USD 6 million (83% of the total planned budget) (Table 9). The CO was successful in mobilization of donor funds for family planning (Government of

Japan), HIV (Global Fund) and maternal health (Japanese Tokyo FM, HelloSmile), and as a result actual expenditure of funds in the SRH focus area has already exceeded the plan.

Table 9. Planned vs actual expenditure, (Million USD)

Focus areas	Planned, 2016-2020	Actual, 2016-2019	Extent of execution
Sexual and reproductive health	4.0	4.3	108%
Adolescents and youth	0.6	0.4	61%
Gender equality and women's empowerment	0.7	0.4	52%
Population dynamics	1.5	0.8	50%
Programme coordination and assistance	0.4	0.2	38%
Total	7.2	6.0	83%

Since 2019 UNFPA CO is part of EU-UN joint programme on Spotlight initiative and UK and UN joint Regional Project on Gender equality, so the expenditure in the Gender equality focus area will increase and related target for resource mobilization will be reached and even exceed in 2020.

The CP expenditure peaked in 2016 and 2017 when UNFPA CO was managing funds provided by the Global Fund that were used to support HIV-related activities (Table 10). In 2016 and 2017 HIV-related expenditure constituted over half of the programme expenditure (68% and 51% respectively).

Table 10. Evolution of expenditure by CP focus area, 2016-2019 (USD).

Focus area	2016	2017	2018	2019	TOTAL
Sexual and reproductive health	1 213 945	1 667 314	703 553	753 936	4 338 748
Adolescents and youth	94 357	69 485	98 159	103 209	365 210
Gender equality and women's empowerment	95 722	88 825	92 010	87 668	364 225
Population dynamics	185 168	171 885	202 612	191 890	751 555
Programme coordination and assistance	41 739	37 603	33 840	36 861	150 043
TOTAL	1 630 930	2 035 112	1 130 174	1 173 564	5 969 780

CHAPTER 4: Findings

This section presents the findings of this evaluation organized around each evaluation question.

Relevance

EQ1. To what extent is the UNFPA support (i) adapted to the needs of the population with emphasis to the most vulnerable population (ii) in line with the priorities set by ICPD Plan of Action and national policy frameworks related to UNFPA mandated areas, (iii) aligned with the UNFPA strategic plan in particular Strategic plan principles (leaving no one behind and reaching the furthest behind), transformative goals, and business model and (iv) aligned with the UN Partnership Framework

CP design was informed by the analysis of the population needs in the UNFPA focus areas. In the course of the CP implementation UNFPA supported assessments that informed adaptation of UNFPA support to the needs of the population, including the needs of the most vulnerable groups. National stakeholders and CP beneficiaries confirmed that UNFPA support through the CP is well adapted to the needs of the target populations.

UNFPA support is in line with the majority of the key areas for future action identified in the Framework of Actions for the follow-up to the Programme of Action of the International Conference on Population and Development Beyond 2014.

The CP contributes to achievement of all three transformative goals established by the UNFPA strategic plan. UNFPA CO put specific attention to reaching the furthest behind through introducing innovative approaches to increase the access of vulnerable groups to SRHR and legal services in remote areas.

Within the framework of this CP, UNFPA used all relevant operational modalities, including service delivery, but used an integrated approach considering the country needs and context when several operational modalities were combined within the framework of every intervention and maintained a strong focus on advocacy and policy dialogue and capacity development.

CP is well aligned with priority approaches emphasized in the UNDAF document. There is a direct alignment between the CP results and intended results set forth by the original version of UNDAF 2016-2020. The revised UNDAF results framework adopted in 2019 captured and expanded UNFPA CP results.

1: CP design was informed by the analysis of the population needs in the UNFPA focus areas.

The CP design was informed by the situation analysis that paid explicit attention to the needs of population, and explicit emphasis on the most vulnerable population. Situation analysis section of the CPD explicitly talks about shortage of health professionals in rural regions; declines in contraceptive use, mainly for women aged 15 - 24 years who have limited knowledge of reproductive health and rights and are subject to family pressures; early marriages and childbearing among adolescents being more common in rural regions and poor families and for women with no or only primary education; sex workers and men who have sex with men being most at HIV infection risk population groups. There is also analysis of the maternal mortality trends and reasons and growing cervical cancer morbidity. All these issues were addressed within the CP.

2: In the course of the CP implementation UNFPA supported assessments that informed adaptation of UNFPA support to the needs of the population, including the needs of the most vulnerable groups.

The evaluation has found a number of examples of assessments conducted within the framework of the CP that informed adaptation of UNFPA support to the needs of the population, including the needs of the most vulnerable groups. For example, in 2017 UNFPA supported an assessment of accessibility and

quality of health services to key populations (SWs and MSMs) at the level of primary health institutions implemented by the Republican Training and Family Medicine Center. Assessment engaged both health professionals and representatives of key populations and provided recommendations for future work. In 2015 UNFPA jointly with UNAIDS, UNDP and AIDS Center supported Population Size Estimation on MSM for 2016. In 2015 to feed 2016-2020 CPD, UNFPA conducted HIV project evaluation with focus on its effectiveness and recommendations for future work.

The studies on access to civil registration conducted by CSO “Tajik Family Planning Alliance” and NGO “Gender and Development” focused on assessing and analyzing the situation of the most vulnerable groups of women, including women with disabilities, single mothers, women heads of households, wives of labor migrants. Study results informed design of the activities conducted within the CRVS project, including mobile consultations and information campaign reaching to vulnerable groups. Analytical study by NGO “Gender and Development” on establishment of evidence on effects of gender inequality and gender-based violence was incorporated into CEDAW reporting and revision of current Law on prevention of violence in the Family (this is on-going).

3: National stakeholders and CP beneficiaries noted that UNFPA support through the CP is well adapted to the needs of the target populations.

National stakeholders perceive UNFPA support as well adapted to the needs of target populations. For example, evaluation respondents noted that HLS courses promoted within the framework of the Adolescents and Youth component are a useful venue for adolescents to learn about SRH, share their concerns and questions, especially because adolescents are not always able to receive this information from parents both due to traditional conservative views and a large number of parents being abroad as labor migrants.

4: UNFPA support is in line with the majority of the key areas for future action identified in the Framework of Actions for the follow-up to the Programme of Action of the International Conference on Population and Development Beyond 2014.

The CPD explicitly says that the 2016-2020 Country Programme “is grounded in the principles of the International Conference on Population and Development (ICPD)”. Analysis conducted by the evaluation team has found that activities implemented within the framework of the CP are in line with 11 out of 15 key areas for action identified by the Framework of Actions for the follow-up to the Programme of Action of the International Conference on Population and Development Beyond 2014.

For example, under the Dignity and human rights pillar one of key areas for future action is ***empowerment of women and girls and elimination of all forms of violence***. The CP supported a number of activities that are in line with this area, for example:

- UNFPA supports operation of the GBV support rooms at the regional maternity clinics.
- The Republican Training and Family Medicine Center conducted ToTs on gender sensitive health services for trainers of regional training centers on family medicine, specifically on detecting gender-based violence cases during provision of health services by family doctors providing consultations and medical services for victims and referral of GBV victims for further assistance. Modules on gender-based violence are mainstreamed into the regular training programs of the Training and Clinical Family Medicine center.
- Standard operational procedures (SOPs) for health, police and psychosocial sectors are introduced to national partners. SOP for health sector professionals have been adapted with the technical support from UNFPA and have been approved by the Ministry of Health and social protection for further mainstreaming. The SOPs include standards for response to violence against both women and girls.
- Staff of the visited reproductive health centers have undergone training on health sector response to GBV supported by the programme.
- UNFPA supported the establishment of the Multi-sectoral working group within the framework of the “Law on Prevention of Violence in the Family”, which is operational and is working towards strengthening inter-agency response and referral network of GBV cases.

- Under the UBRAF funds UNFPA regularly strengthened capacity of medical personnel, namely family doctors, to remove stigma and discrimination against SWs.
- In 2016, 1,039 sex workers received consultations and support from lawyers. They mostly sought advice and assistance included: the norms and legislation of the Republic of Tajikistan regarding sex workers, including stigma and discrimination; detention procedures by law enforcement agencies and what to do in case of arrest; changes in legislation relating to sex workers; divorce and claims for spousal support where there was no marriage registration; women's rights in religious marriages; sex workers wanting to know where to obtain shelter; and, preparation of documents for employment and other issues.

Under the Health pillar one of key areas for future action is to **protect and fulfil the rights of adolescents and youth to SRH education and health services**. Examples of UNFPA support in this area include:

- HLS course developed and introduced to 260 schools with the CP support offers adolescents an opportunity to learn about SRH, share their concerns and questions.
- The CP supports mobile outreach events that are organized once per year and gather adolescent girls in the regions, engaging them in three hours interactive information sessions on reproductive health issues.
- The CP supported development of a mobile app for adolescents jointly with NGO Tajik Family Planning Alliance that provides access to quality SRH information.

The table with results of the analysis of alignment of the UNFPA support with the Framework of Actions for the follow-up to the Programme of Action of the International Conference on Population and Development Beyond 2014 is available in the section A1.2 of the Evaluation Matrix (Annex 4).

5: UNFPA CO pays specific attention to reaching the furthest behind through introducing innovative approaches to increase the access of vulnerable groups to SRHR and legal services.

The UNFPA CO pays special attention to reaching to the furthest behind. For example, within the CRVS project UNFPA supported the assessment of accessibility of civic registry services for vulnerable groups of population, including labor migrants, single mothers and people with disabilities. The study helped to identify villages with the lowest level of awareness and knowledge about civic registration services. These villages were targeted by interventions, including forum theatre information campaigns and mobile consultations. Vulnerable groups of population in the selected villages benefitted from these interventions, but positive impact was limited only to these selected villages.

The same pattern is present under the other components of the CP. Under the Gender focus area UNFPA supported innovative approach namely “Public Health Fairs” to selected rural jamoats (municipalities) for prevention of GBV, harmful practices and increase of access of women and girls from remote rural areas to legal and health services. Public Health Fairs bring qualified SRH professional, psychologists and legal advisors who provided free services to women and girls in remote rural areas. Selection of target municipalities is done in consultation with health authorities and women committees. For example, in 2018 one of Health Fairs was conducted in the village of Obodi in the Istaravshan district of Sugdh province. Obodi was selected because the low use of the SRH services by local women, high maternal mortality and early marriages. Additionally, this innovative approach bringing services to vulnerable groups of remote areas helped CP to reach migrant’s wives and children, people with disabilities and PLWH with SRHR and legal services. Within the current CP ten PHFs are conducted based on availability of funds.

UNFPA is one of the few agencies working with MSMs and SWs under the HIV component. To reach SW and MSM UNFPA developed an “umbrella” modality and worked with 19 NGOs as sub-sub recipients. This innovative modality reached the communities quite directly and contributed to strengthening the capacity of the non-government sector and improving referrals and coordination between communities and the government health services including primary health care institutions at the district and rural areas. Outreach workers are the backbone of the approach. UNFPA Tajikistan has invested in the capacity strengthening of 19 NGOs working with men who have sex with men and sex workers in case

management; 12 NGOs received training on the management of STIs including referral, early diagnosis and counselling; all 19 NGOs improved their performance in commodity supply management; monitoring, evaluation and reporting, crisis management; community empowerment and outreach. Particular attention was paid to outreach, which is a critical component of the umbrella approach. Acknowledging low education, limited experience in the health sector, low rates of pay and high burn out, UNFPA Tajikistan has worked with the NGOs to examine concrete ways to improve the quality of service, improve the capacity of the outreach workers to deliver, and to increase the support structures for the outreach workers. During 2016 and 2017 UNFPA coverage was impressive: 12490 SW and 12182 MSM with minimal package of services (condom distribution, IEC and counseling);

The SWIT, YKP have been adopted by the Ministry of Health for use at the primary health care level and translated into Tajik language. The tools are central to UNFPA’s overall response to HIV among key populations. Roll out events on the SWIT, YKP were carried out with the sex work community, NGOs and government specialists from AIDS Centers, STI Centers and Reproductive Health Centres.

6: The CP contributes to achievement of all three transformative goals established by the UNFPA strategic plan.

Strategic plan 2018-2021 highlights that UNFPA embraces the vision set forth in the 2030 Agenda. UNFPA organize its work around three transformative and people-centred results in the period leading up to 2030. These include: (a) an end to preventable maternal deaths; (b) an end to the unmet need for family planning; and (c) an end to gender-based violence and all harmful practices, including female genital mutilation and child, early and forced marriage

The CP is well aligned with these transformative goals. The CP takes explicit responsibility for reducing the Maternal Mortality Ratio and increasing the Contraceptive Prevalence Rate (Table 11). The CP also has to contribute towards greater awareness of the public and policy-makers about negative effects of gender-based violence and adoption of new policies addressing gender based violence (Table 11), which shall contribute to ending gender-based violence.

Table 11. Alignment between the CP design and UNFPA transformative goals.

UNFPA transformative goals	CP outcome and output indicators
End to preventable maternal deaths	Outcome indicator: Maternal mortality ratio (per 100,000 live births) Baseline: 33; Target: 25
End to the unmet need for family planning	Outcome indicator: Contraceptive prevalence rate (modern) Baseline: 30%; Target: 37%
End to gender-based violence and all harmful practices, including female genital mutilation and child, early and forced marriage	Output indicators: <ul style="list-style-type: none"> ● Number of analytical studies to establish evidence on effects of gender inequality and gender-based violence conducted to guide policy ● Number of new policies addressing gender inequality, gender based violence and gender biased sex selection developed ● Number of public campaigns addressing gender equality, non discrimination and gender based violence and gender biased sex selection, including through engagement of men and boys

7: There is a strong national demand for provision of direct services which runs counter the UNFPA business model for Tajikistan that excludes service delivery and individual capacity development (since 2018) from the list of eligible operational modalities that can be supported by UNFPA core funds. Within the framework of this CP UNFPA used all operational modalities, including service

delivery, but used an integrated approach considering the country needs and context when several operational modalities were combined within the framework of every intervention and maintained a strong focus on capacity development and advocacy and policy dialogue.

The UNFPA strategic plans 2014-2017 and 2018-2021 limit the types of operational modalities that can be supported: since 2014 UNFPA should not use its core funds to support service delivery and since 2018 it should not support individual capacity development and focus on building institutional capacities and enabling environment. Partnerships and coordination, including South-South and triangular cooperation, knowledge management, as well as advocacy, policy dialogue and advice can be deployed fully (see Table 6). Evaluation of the previous country programme has also recommended that “In terms of strategic interventions, while continuing to build national capacities, UNFPA CO to increase investments in advocacy and policy dialogue, and (continue to) identify ways to reduce service delivery”⁴⁶.

The evaluation data indicates that configuration of the business model for Tajikistan undermines UNFPA CO ability to respond to the needs articulated by the national stakeholders, including the most vulnerable groups (e.g. SWs and MSMs). Representatives of health institutions visited by the evaluation team were consistently talking about the need for additional equipment, supplies and staff trainings that cannot be covered using the available state and local funds. The major challenge will be the transition of the Global Fund from Tajikistan and the end of the UNFPA sub recipient grant. There are many concerns from the community and a fear that there will no longer be SRH services for sex workers and men who have sex with men; there will be increased stigma, discrimination and gender-based violence; lack of trust towards health service providers will increase without the Trust Point support; community empowerment efforts will end and will not be seen as a relevant by the government; STI and HIV will increase with a commensurate decrease in the availability of condoms, lubricants, and HIV tests; NGOs will have little or no access to funds from the government; and there will be no investment in the institutionalization of integrated SRH/HIV/STI services at the primary health care level.

The evaluation team has also found that in most cases UNFPA supported provision of direct services within the projects that were supported by external donors: TokyoFM (Hello Smile), The Global Fund, Government of Japan, the SDC. Nevertheless, even within those projects UNFPA put a strong emphasis on systems strengthening, building individual and institutional capacity of service providers that was challenging areas for the country. For example, UNFPA was supporting building individual capacity of outreach workers and institutional capacity of NGOs providing services to SWs and MSMs, including supporting networking between these NGOs and building their management and reporting capacity so that they can become equal partners to other donors. Due to this support NGOs networks were able to continue service provision, yet on a much smaller scale, by successfully participating in competitive bids for service provision run by UNDP and getting grants from other organizations. In addition, UNFPA is currently using lessons learned from service delivery to SWs and MSMs to advocate for integration of such services in the operation of the national health system.

The CP has explicit focus on engaging in advocacy, policy dialogue and advice: there are output indicators with set targets for UNFPA contribution towards adoption of new national plans, policies guidelines, protocols and standards, which is achieved. UNFPA was also widely using knowledge management operational modality by supporting assessments and studies to inform planning on implemented activities. UNFPA CO constructive involvement all UNCT coordination mechanisms, including Operations Management Team, Theme Groups, UNDAF Result Group, REACT, indicates the use of partnerships and coordination modality. The evaluation team has also observed use of South-South and triangular cooperation though they are limited within certain programmatic areas.

⁴⁶ Country Programme Evaluation. UNFPA Tajikistan Country Programme 2010-2015 Evaluation Report. November 2014

8: CP is well aligned with priority approaches emphasized in the UNDAF document. There is a direct alignment between the CP results and intended results set forth by the original version of UNDAF 2016-2020. The revised UNDAF results framework adopted in 2019 captured and expanded UNFPA CP results.

The evaluation has found that the CP is well aligned with priority approaches emphasized in the UNDAF document. UNDAF document highlights that application of comprehensive capacity development approach (at systemic, institutional and organizational levels) should be a crosscutting principle used by all UN agencies. UNFPA was consistently using this approach within the CP: all four CP components included training activities for national stakeholders.

UNDAF document also says that UNCT support shall place emphasis on awareness and assumption of responsibility by authorities in constructive coordination with the civil society partners for assessing, prioritizing and responding to the needs of those who are most vulnerable, socially excluded and/or disadvantaged and at risk of being left behind as the country progresses. Under the HIV component of the CP UNFPA supported establishment and operation of NGO networks working with SWs and MSMs who are highly vulnerable to HIV infection and at the same time socially excluded as well as efforts of these networks to engage with authorities to promote service delivery models responsive to the needs of SWs and MSMs.

The MoHSP is conducting health reform processes and implementing family medicine as one of solution to universal health coverage for all at all levels under the SDG objectives. In this context, under SRH component, CP focused on strengthening the primary health care system through introducing new programmes and capacity building activities in order to improve the quality of integrated health services in rural areas.

The evaluation has also found that there a direct alignment between the CP results and intended results set forth by the original version of UNDAF 2016-2020:

- The SRH component of the CP was contributing to UNDAF Indicator 3.9. Maternal mortality ratio (per 100,000 live birth) under UNDAF outcome 3: People in Tajikistan benefit from quality, equitable and inclusive health, education and social protection systems. In addition, UNFPA efforts to strengthen national capacity to develop and regularly update contingency plans that address the sexual and reproductive health needs of women, adolescents and youth in crisis situations (output 2 under SRH component) were contributing towards achievement of UNDAF Indicator 6.6. Number of disaster impact alleviation plans and policies (at all levels) under UNDAF outcome 6: People in Tajikistan are more resilient to natural and man-made disasters and benefit from improved policy and operational frameworks for environmental protection and sustainable management of natural resources.
- The Youth component of the CP was contributing to UNDAF Indicator 3.14 Percentage of young women and men aged 15-24 years who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission under UNDAF outcome 3: People in Tajikistan benefit from quality, equitable and inclusive health, education and social protection systems.
- The Gender component of the CP was contributing to UNDAF Indicator 5.2. Gender Gap Index under UNDAF outcome 5: Women, youth, children, persons with disabilities and other vulnerable groups are protected from violence and discrimination, have a voice that is heard and are respected as equal members of society.
- The P&D component of the CP was contributing to UNDAF Indicator 1.5. New national development strategies are developed based on human rights, accurate evidences and consider accepted international development frameworks (SDG, ICPD, CEDAW etc.) under UNDAF outcome 1: People in Tajikistan have their rights protected and benefit from improved access to justice and quality services delivered by accountable, transparent and gender-responsive legislative, executive and judicial institutions at all levels.

In 2017-2018 UNCT undertook a series of reviews and assessments to improve the measurability and evaluability of the UNDAF. This work resulted in a revised UNDAF results framework, encompassing a set of high quality, measurable, achievable and time bounded UNDAF outcome indicators made effective in 2019.

The revised results framework introduced new indicators considering the relevance of some indicators to outcome level indicators and avoiding stand-alone approach by single UN agencies:

For instance, in Outcome 3 Health, two new indicators “Women attended at least four times during pregnancy for ante-natal care”, “Births delivered by skilled health personnel/ at health facility” are included which measuring maternal mortality. Hence, UNDAF International expert regarded MMR to goal indicators. Two indicators “Knowledge about HIV among young people”, “Gender Gap Index” are dropped only due to reasons mentioned above. At the same time several indicators directly related to UNFPA worked were added: Indicator 5.1 Presence of new or strengthened legal and policy frameworks to promote, enforce and monitor gender equality and non-discrimination, including GBV and SRH, in line with international standards (SDG 5.1.1); Indicator 5.6. Number of civil society networks engaged in programmes that address sexual and reproductive health needs of women, youth, children, persons with disabilities and other vulnerable groups, including refugees and stateless persons (SDG 3.8.1, 17.17); Indicator 5.7. Extent of implementation of legal and policy frameworks that address gender-based violence (GBV), including intimate partner and domestic violence, in line with international standards (SDG 5.2.1, 5.2.2). One new indicator “Number of targeted SDG indicators for which reliable national data are available, disaggregated by sex (contribute to SDG17.18.1)” was proposed for outcome 1 of UNDAF.

Effectiveness

EQ2. To what extent have the intended programme outputs been achieved?

EQ3. 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 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?

The CP has reached all targets for its outputs and outcomes in the Sexual and Reproductive Health focus area and made achievements beyond the initial programme results.

The CP has reached all targets for its outputs and outcomes in the Adolescents and Youth focus area.

The CP has reached all targets for its outputs and outcomes in the Gender equality and women’s empowerment focus area.

The CP has reached most of the targets for its outputs and outcomes in the Population dynamics focus area and is on track for reaching the remaining ones.

9: The CP has reached all targets for its outputs and outcomes in the Sexual and Reproductive Health focus area and made achievements beyond the initial programme results.

Outcome: Sexual and reproductive health Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access.

Indicator	Baseline	Target	Actual
Maternal mortality ratio (per 100,000 live births) Baseline: 33; Target: 25	33	25	24 (2018, MoHSP)
Contraceptive prevalence rate (modern) Baseline: 30%; Target: 37%	30%	37%	40,1% (2018, MoHSP)
Percentage of sex workers who have received an HIV test in the past 12 months and know their results Baseline: 55,7%; Target 70%	55,7%	70%	70%

Output 1: Increased capacities of institutions to deliver integrated sexual and reproductive health services by strengthened evidence based policy frameworks and institutional mechanisms.

Indicator	Baseline	Target	Actual
Number of new national plans and policies that prioritize universal access to sexual and reproductive health.	0	3	3
Number of new guidelines, protocols and standards for health-care workers developed for delivery of integrated age and gender-responsive sexual and reproductive health services (including on cervical cancer).	1	4	4
Percentage of primary health-care facilities in pilot region providing integrated sexual and reproductive health services (including cervical cancer screening).	0%	30%	100% (in pilot regions)
Maternal death surveillance and response system established and operational at national level.	No	Yes	Yes
Percentage of service delivery points providing at least three types of contraceptives.	65%	85%	85% (2018, MoHSP)
Percentage of reproductive health centres and primary health-care facilities delivering integrated sexual and reproductive health services to marginalized youth and key populations.	0	30%	60%

There is evidence of significant progress for Output 1, Increase capacities of institutions to deliver integrated sexual and reproductive health services by strengthened evidence-based policy frameworks and institutional mechanisms, and these improvements are strongly contributed to reduce maternal and neonatal mortality, which is confirmed by national data and UN estimate. Worthy of note that according to recent UN estimates, the maternal mortality has positive trends and declined by 68% during 2000 and 2017⁴⁷.

Evidence of this, there is a clear evidence of success in the National action plan on Reproductive health, Maternal, newborn, child and adolescence health (2016-2020) development and implementation process: strong assessment process, reorganization MCH system within effective perinatal care (EPC), support for confidential audit of maternal deaths, near miss case review, standard and protocol development and trainings on EPC and EmOC with monitoring and supportive supervision, integration of SRH with family medicine, promotion midwifery programme.

The current CP supported FP trainings directly address an acute need for competency-based training for FP provider clinical skills, such as FP quality counselling and service provision, IUD insertion and postpartum contraception including through South South & Triangular Cooperation, b) for the first time government established budget line for SRH supplies in state budget and started process of allocation of funds from the state budget for the purchase of contraception, and c) implementation of the first pilot project on CCP (cervical cancer prevention) in Tajikistan. Despite a limited budget, UNFPA does exceptional work on HIV and AIDS, especially in the context of key population.

⁴⁷ Trends in Maternal mortality for 200-2017, UN Estimate

Based on a review of national and regional data, program documents and stakeholder interviews, UNFPA CO thanks to strong policy advice and continues evidence based advocacy succeeded in development and implementation of a number of national strategies/documents:

- National Development Strategy up to 2030;
- Medium-term Development Programme for 2016-2020;
- National action plan on Reproductive, Maternal, Newborn, Child and Adolescence health (2016);
- Health code of Tajikistan (2017);
- Strategic plan for the development of family medicine-based primary health care in the Republic of Tajikistan (2016–2020);
- National Program on SRH for 2019-2022;
- National Communication Strategy on SRH;
- National HIV prevention programme 2018-2021

Along with this, CO as a member of DCC Health and the National Steering Committee on Health and technical groups contributed to development of new Comprehensive Health Strategy for the period of 2020-2030.

In programming UNFPA CO relied on evidences collected through needs assessments and analyses of services at the primary health care and maternity houses levels by international and national experts. Assessments of quality of services for mothers and newborns at the hospital and PHC levels using WHO tools were an integral part of improving quality of care and implementing international standards on maternal and child health in the clinical practice. These assessments helped the Ministry of Health and Development Partners to identify key areas of pregnancy, childbirth and neonatal care that need to be improved. UNFPA long term and systematic approach to reorganization of MCH services according to effective perinatal care technologies, introduction of national standards, clinical protocols and near-miss cases review and their implementation in maternity clinics was instrumental in terms of reducing maternal and neonatal mortality and morbidity.

UNFPA is leading agency in introduction of Effective Perinatal Care (EPC) programme and Beyond the Number (BTN) in Tajikistan since 2008. In collaboration with Development Partners, UNFPA supported introduction of updated EPC package, new training programme on EmOC and clinical protocols on resuscitation in obstetrics at the national and regional levels followed by monitoring and supportive supervision. This package is highly appreciated by national partners as one of important tool for improving quality of care and reduction of maternal and newborn morbidity and mortality. During supervisory visits, special attention was given to developing facility-based plans for improvement of clinical emergency obstetrics practices, identification of measurable indicators and improvement of management and teamwork of health facilities, which has resulted in a significant reduction in the use of general anesthesia methods and reduction in eclampsia and postnatal bleeding at the national and province levels.

Stakeholders repeatedly cited the importance of UNFPA support for the roll-out of the WHO “Beyond the numbers” methodologies in identifying priority interventions to help reduce maternal mortality. Due to the implementation of mentioned methodology the quality of EmOC improved, internal protocols are developed and in place. This facilitated the MoHSP with development of the National Guideline on Perinatal audit. Nevertheless, near-miss cases review is fully operational in 20 maternity clinics piloted and supported by UNFPA out of 36 total second and third level pilot maternity clinics supported by other development partners (DPs), which requires additional joint work with DPs on addressing challenges towards achievement of strategic goal to end all preventable maternal deaths.

Evaluation team determined that those maternity houses implementing both NMCRs and EPC have positive results in quality of services: increase of facility-based deliveries and skilled birth attendance, decrease of earlier and post-delivery bleedings, uterus rupture and hysterectomies, hemorrhagic shock and suppurative septic complications. Another important observation was decrease of childbirth

trauma. Thanks to rights and choice based approaches health professionals noted positive mood of pregnant women during delivery and decrease of postnatal depression due to rights and choice based approach. Considering cost effectiveness, efficiency and relevance of EPC programme and standards to country context, it needs to be expanded in rural and district maternity houses.

Some of the visited clinics reported that they had no cases of maternal mortality thanks to implementation of EPC and BTN. Stakeholders at both the national and regional level provided evidence for significant improvements in emergency obstetric care that are strongly contributed to reduce the risk of maternal death and morbidity which is directly linked to UNFPA supported activities.

Examples include the development and approval of several UNFPA supported EmOC protocols (such as the introduction of protocols on management of postpartum hemorrhage and induced labor, management of physiological pregnancy, FP National standards).

There is a clear evidence of success in conducting EPC trainings, with positive evidence of impact in recent data for neonatal indicators. UNFPA supported interventions for Enhanced Prenatal Care training and supportive supervision were repeatedly cited as contributing to improved perinatal outcomes as a result of improvements in a wide range of practices (neonatal resuscitation, rooming in of mothers, skin-to-skin contact, umbilical cutting procedures, vertical delivery, management of eclampsia). Despite these promising results, stakeholders mentioned that there are chronic problems in country with pre-service education for OB/Gyns, Family Doctors, Nurses and Midwives. Practical training for clinical skills, such as C-section, vacuum extraction or IUD insertion, are not adequately addressed. Without short-term efforts to improve medical care to be competency-based, it will be difficult to sustain the progress made so far.

Aiming at improvement of the quality of education and acquire competency-based skills, UNFPA involving WHO, provided technical support to the Republican Medical College for the revision and updating the basic midwifery training program in cooperation with the Ministry of education and science. The updated curricula meets the requirement of International Confederation of Midwives. Tutors of republican medical college reported that for more than 17 years midwives were trained as nurses at the first three years of basic education and only fourth year was devoted to learning midwifery programme. Hence, most challenges in terms of theoretical and practical skills of midwives came from these missed opportunities. They highlighted that thanks to UNFPA initiative and support they have started introducing the new updated curricula for basic education of midwives in 2018 teaching them from the beginning as midwives but not nurses. Tutors of medical colleges are trained within updated midwifery programme. Along with this UNFPA supported Republican and regional medical colleges with the establishment of a training center for Virtual Interactive Contraception training package.

Along with this, the role of midwives in provision of SRH, MH, FP and CCP services is still limited and regulation framework need to be strengthened as a further step. Though the National Association of midwives was established in 2014 with support of UNFPA but the management and team composition of association has been changed several times and lack the leadership skills.

CPE team found out that the MoHSP is introducing new district health information system (DHIS-2). UNFPA supported capacity-building activities for introduction of DHIS-2. CPE team noted that this is an effective channel for introduction of Register of women on RH&R and the Republican Health Statistic and Information Center could be considered as national strategic partner for development of this area. DHIS-2 have different types of reports and need to be used more broadly within UNFPA CP considering existing capacity and relevant system for programming and planning.

CPE team familiarized with Assessment Report prepared by International expert on implementation of pilot cervical cancer prevention project funded by HelloSmile consortium and based on CPE team field visits and findings agreed with outcomes of assessment. 1) A pilot model of organized cervical cancer screening and pre-cancer treatment was introduced for the first time in the country achieving over 93%

of coverage of the target population. 2) New recording/reporting system based on the “Comprehensive Cervical Cancer Control” guide of WHO and including other SRH related indicators was introduced. This new form allowed collecting information on various conditions related to SRH from women who received CCP screening. 3) A clear and targeted information campaigns facilitated dialogue and raised public awareness and their participation at the early detection of cervical precancerous diseases and other RH issues. 4) Coordinated multi-sectoral cooperation for improving women’s sexual and reproductive health created a platform for further collaboration of local government authorities to address other public health issues in Khatlon and Sugd provinces.

The pilot project also made achievements beyond the initial project objectives: a number of other Reproductive health issues (contraception, myoma, extragenital diseases, etc.) were identified and addressed; capacity building activities contributed to improvement of overall SRH services that meet internationally agreed evidence-based standards and significantly contributed to the institutionalization and sustainability of the SRH programme.

However, it should be noted that the situation with cervical cancer is alarming in the country. According to WHO surveys 400 women of reproductive age are dying from this preventable death in Tajikistan. There is no coordination mechanism and reliable data on this area. Capacity of service providers is weak in diagnostic and treatment and need to be strengthened. UNFPA supported a number of sequential actions but within availability of funds. CO involved WHO and other partners and they made contribution in some activities of this area but still funds were insufficient.

UNFPA-supported integration of SRH and FP services into the PHC were associated with increased knowledge of family doctors and nurses and population on pregnancy and labor. In order to improve the accessibility of family planning methods and increase capacities of institutions to deliver integrated sexual and reproductive health services, a series of trainings on FP, long & permanent methods like IUD insertion including in post-partum period and rights-based voluntary surgical sterilization were conducted. Mostly trainings were organized for midwives from selected rural villages. Each midwife who received the certificate was equipped with a kit for inserting and removing IUDs. Each trained midwife in average inserted 80 IUDs. Post-partum FP trainings were targeted at the midwives of maternity houses who are in charge of counselling and service provision on FP. Huge efforts were also made to ensure that teachers of Republican and Regional Family Medicine centers are re-trained on family planning counselling and teaching techniques.

In parallel, UNFPA technical support to MoHSP was provided for development of Clinical Protocols on voluntary surgical sterilization and modern methods of contraception based on the updated WHO Global Handbook on Family Planning. It worth mentioning that all capacity-building interventions are based on the family planning situation analysis conducted jointly by the team of MoHSP and International Expert.

The implementation of the CHANNEL Logistics Management Information System software system and continuous capacity building is major accomplishment. Based on site visits and stakeholder interviews, it was clear that the system is being used effectively to monitor the stocks of contraceptives according to type and expiration status. All Reproductive Health Centers specialists had a knowledge of the current status of every method. The system permits regions to identify locations where there are possible stock outs and where there is excess supply that can be shared with locations that lack supplies.

Under the HIV component, UNFPA build capacity of NGO “Apiron” to advocate for SW and MSM rights through various coordination meetings, platforms, etc. In 2018 NGO “Apiron” submitted shadow report to CEDAW General Assembly 72 on the situation with SWs in the country. As a result, CEDAW Committee made recommendations to the country to address those findings and report back.

Output 2: Strengthened national capacity to develop and regularly update contingency plans that address the sexual and reproductive health needs of women, adolescents and youth in crisis situations.

Indicator	Baseline	Target	Actual
Number of new or revised national and regional humanitarian contingency plans that include elements of Minimum Initial Service Package and address the sexual and reproductive health needs of women, adolescents and youth in crisis Baseline: 1; Target: 4	1	4	4 (2018)

There is clear evidence of impressive progress in activities for Output 2, to strengthen national capacity to develop and regularly update contingency plans that address the sexual and reproductive health needs of women, adolescents and youth in crisis situations. For that purpose, UNFPA made a strong advocacy to MoHSP to establish a dedicated Thematic WG on SRH in Crisis under official MoHSP decree in 2016 with its statement, ToR and annual work plan. With that achievement, UNFPA in collaboration with the members of the Thematic SRH WG in crisis were able to: 1) Develop and approve National and 3 Regional Action Plans on SRH in emergencies; 2) Roll-out Minimum Initial Service Package for SRH in Crisis including ASRH needs nationwide covering 160 RH staff 3) Develop and introduce SOPs and Clinical protocol on provision of health care services to the victims of GBV 4) Ensure that SRH and Gender aspects are integrated at the Inter-agency contingency plan of UN agencies and National DRR Strategy till 2030; 5) Assisted MoHSP to stockpile dignity kits to respond to emergency situations.

Providing SRH services to women and adolescents and protecting them from violence during disasters is not an easy task. In addition, no other organization deals with this issue. UNFPA advocacy affords to ensure that SRH and GBV concerns are integrated into the national emergency preparedness and response plans and the need to establish dedicated platforms were fully accepted by the Government and currently there are two platforms such as Thematic SRH Working Group in Crisis established under the MoHSP official order and Multi-sectoral GBV coordination platform lead by the Committee for Women and Family Affaires.

This allowed, UNFPA to introduce capacity building packages on SRH and GBV, develop National and Regional Action Plans of SRH in emergencies and interventions to provide SRH services for women and adolescents during disasters. As result, regions like GBAO, Sugdh and Khatlon developed Annual SRH Action Plans in Crisis. The Action plans were improved though involving PHC managers and obstetric/gynecologists. These activities allowed the government to take a more serious look at the problems and ensure that SRH and GBV concerns are integrated in the National Disaster Risk Reduction Strategy 2019-2030 as recommended by the Sendai Framework for DRR 2015-2030.

10: The CP has reached all targets for its outputs and outcomes in the Adolescents and Youth focus area.

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

Indicator	Baseline	Target	Actual
Number of new policies and programmes in place addressing sexual and reproductive health needs of youth and adolescents, including marginalized youth.	0	3	3

Output 1: Increased capacity of national institutions and networks to conduct evidence based advocacy for incorporating adolescents and youth rights in national laws, policies and programmes.

Indicator	Baseline	Target	Actual
Number of UNFPA supported youth platforms that advocate for increased investments in youth and adolescents, including marginalized youth, within development policies and programmes	1	6	5

Number of civil society networks supported by UNFPA that engage in programmes addressing sexual and reproductive health needs of marginalized and vulnerable groups, people living with HIV and key populations	4	10	19
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Output 2: Increased participation of civil society organizations in promoting sexual and reproductive health and rights of vulnerable and marginalized youth groups.

Indicator	Baseline	Target	Actual
Number of civil society interventions completed with UNFPA support that address adolescent girls at risk of early marriage and harmful practices.	0	8	6
Proportion of secondary high schools that have adopted healthy lifestyle education, following international standards for grades 10 and 11	0	10% (320 schools)	On track: 260 schools 81% of target (as of 2019)

UNFPA CP has been extensively focusing on addressing the needs of vulnerable and marginalized adolescents and young people. The focus has been primarily on increasing access to comprehensive sexuality education, HIV and STI prevention, reduction of stigmatization and discrimination of key population and increasing access to youth friendly and integrated sexual and reproductive health services. Capacity building of relevant governmental institutions, youth platforms and civil society organizations, provision of direct technical support, facilitation of better coordination, advocacy and sensitization have been among the main working approaches during the evaluation period.

Through capacity building grants, implementing partners of UNFPA among existing youth organizations and platforms increased their technical expertise in delivering services as well as general organizational development, including overall management, monitoring and reporting, strategic partnership building with national state institutions and other relevant INGOs for furthering youth and adolescent agenda. National Y-PEER Network (Hamsol ba Hamsol) has been capacitated to promoting community-based peer education and healthy lifestyle education within secondary school in cooperation with Academy of Education, Ministry of Education and Teachers` Training Institute.

Since 2018, Y-PEER is conducting mobile outreach on covering girls in rural areas with basic sexual and reproductive health information and 3-4 ToTs on HLS per year engaging secondary school teachers, mainly those who teach biology. The HLS courses are currently being taught in pilot schools once a week for eight weeks as part of the existing system of open hour devoted to discussions and learning of various issues not covered by the main school program.

Focus group discussions conducted with teachers who participated in the ToTs and currently teach HLS in pilot secondary schools demonstrated high level of willingness and overall adequate capacity to deliver the HLS courses. Teachers in majority of schools have shared the materials and information with their peers thus transferring the knowledge further and building the institutional memory within their respective schools. However, it should be noted that teachers expressed certain challenges with delivering information on specific sensitive (condom use, STI, sexual relations, sexuality, etc) topics within SRH, where according to them health professionals would be better fit to respond to the needs of the students. Discussions with secondary school children demonstrated that HLS courses have been warmly welcomed by adolescents in relevant schools and they have genuine interest in the topics. In the absence of other youth friendly, accessible and reliable SRH information, these courses are paramount to secure adolescents from SRH related risks and dangers. Students express interest in the courses, share positive feedback and can elaborate on SRH topics. UNFPA is the only actor in promoting HLS at secondary school level in the country for the time being and thus partnership with Ministry of Education considered as strategic towards institutionalization of HLS. Having said that, in 2019 UNFPA signed IP agreement with MoE to increase ownership for HLS and thus ensure sustainability of HLS activities.

In 2017, the MoHSP has established 21 medical-consultancy cabinets (centers) for youth (MCCY) in 12 districts within five regions. UNFPA contributed with strengthening capacity of MCCYs responsible staff and provided them with adapted WHO OP manual. During FGDs with students of secondary schools undergoing HLS courses and teachers delivering HLS courses, majority of the participants did not possess any information about the existing MCCY within their districts and the type of services they provide. (can we indicate the reason, e.g. location of YFC, proximity to school, etc). More meaningful integration of MCCY staff in the HLS education would strengthen the impact and positively contribute to the work of HLS teachers.

UNFPA CO provided support to civil society organizations in promoting sexual and reproductive health and rights of vulnerable and marginalized youth groups. During 2016, UNFPA CO was engaged with strengthening capacity of 19 CSOs working on prevention of promotion of sexual health and rights of SW and MSM. Specifically, these services included functioning services of Trust Points, counseling and HIV/STI testing services, distribution of commodities (condoms, IEC, counseling and referral) to MSM and SW groups, advocacy and community mobilization, building leadership and self-worth of key population. Interviews conducted with some of the CSOs demonstrate in-depth understanding of specific vulnerabilities and needs of MSM and SW among staff contributing to the effectiveness of their work with key population. Even though UNFPA has not been engaged with the same project through collaboration of 19 CSOs beyond 2018 and UNDP has taken over the initiative, these CSOs still have trusted relationships and engagement with SW and MSM groups they have worked with previously. MSM and SW expressed appreciation and satisfaction with the services they were receiving in 2016 and emphasizing importance of the approach UNFPA was taking in engagement with key population. Specifically, they mentioned that services were provided in a respectful and sensitive way, outreach work was effective and contributed to coverage of large number of key populations, services were not simply limited to commodities distribution but more holistic, rights-based approach. *“UNFPA approach to provision of services for MSM was more comprehensive, we had site visits among outreach workers from MSM, certain activities contributing to psychological coping with our specific challenges. I experienced self-stigmatization and stigmatization from others. After cooperation with UNFPA as an outreach worker, I gained more self-respect”* (MSM Focus group respondent).

In parallel with engaging CSOs, UNFPA has been promoting sexual and reproductive health and rights of vulnerable and marginalized youth groups through collaboration with state institutions. In 2016 UNFPA CO signed a partnership agreement with Republican AIDS Center to increase ownership for HIV response. Jointly with AIDS Center UNFPA CO facilitated an initiative to establish a Technical Working Group (TWG) on integration of SRH/HIV/STI services for key populations at PHCL. In 2017 UNFPA CO documented the Trust Point (TP) model to ensure comprehensive integrated SRH services; improving the integrated services for key pop at primary health care level. Focus group discussion with MSM group at the premises of one of the Trust Points which operated until 2017 showed considerable difference in provision of services to key population in a non-discriminatory and sensitive way. Focus group participants among MSM highly appreciated the professional attitude of the staff of this Trust Point, and the evaluation team observed that FGD participants among MSM unlike in other places were feeling safe and secure at the premises. In the absence of adequate services, currently key population refer to trusted doctors, who have made good partnership and sustain relationships with UNFPA NGO partners from 2016. However, based on other FGDs not all Trust Points and integrated services have the same level of sensitivity and professionalism in working with key population. In order to further enable integration of SRH/HIV/STI services to meet the specific needs of key population, UNFPA in partnership with IP among CSOs organized a technical visit for HIV/STI/RH centers deputy directors to Trust Points operating under different modes and an integration roadmap was developed and submitted to MoHSP. UNFPA partners among CSOs have been promoting the issue further through advocacy, round table discussions and other venues.

11: The CP has reached all targets for its outputs and outcomes in the Gender equality and women’s empowerment focus area.

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

Indicator	Baseline	Target	Actual
Proportion of CEDAW concluding observations on sexual and reproductive health and gender based violence from previous reporting cycle implemented or action taken	To be set	50%	50%

Output: Strengthened capacity of institutions to enable delivery of multisectoral services and to address gender based violence and discrimination in line with international human rights treaties obligations.

Indicator	Baseline	Target	Actual
Number of analytical studies to establish evidence on effects of gender inequality and gender-based violence conducted to guide policy	1	3	3
Number of new policies addressing gender inequality, gender based violence and gender biased sex selection developed	1	3	3
Number of public campaigns addressing gender equality, non discrimination and gender based violence and gender biased sex selection, including through engagement of men and boys	10	15	27

UNFPA CP for the period of 2016-2019 steadily worked towards achievement of the outcome on advancing gender equality and responding to the needs of most vulnerable women and girls. Further institutionalization of VSRs located within maternity houses have significantly contributed to the effectiveness of the service provision to victims of gender-based violence (GBV) among women and girls. In the period of 2013-2019 (7 month) – VSRs provided gender sensitive services to almost 860 victims of GBV and sexual violence. Visit of the evaluation team to three VSRs in Khatlon and Sughd provinces validated the statements of other local actors involved in the referral system of GBV victims, specifically victims of domestic violence (DV) on effectiveness and crucial role of VSRs as response mechanism. The location of the facilities within maternal houses, interior arrangement of the rooms and increased gender sensitivity of the responsible focal points positively contribute to the help-seeking behavior of potential GBV victims with significant number of women referring to the VSRs for help. Women of different ages and experiences of DV have been referring to victims` support rooms for help, including older women, adolescent girls, women with children who have an opportunity to be sheltered together with their minor children. *“I have been here for three days now; I feel much better. I needed a place with some privacy to think and digest what happened to me. None of my relatives except niece knows where I am. Staff of this facility supported me and provided me with medicine and meal”*. It should be noted that staff of VSRs have been handling cases with different forms of GBV, including highly sensitive cases such as marital rape and teen pregnancies in a delicate and effective way. The adopted regulation of MoHSP on the operation of the VSRs specifying the types of services available in the premises and specification of domestic violence as a specific form of GBV that VSRs are mandated to respond and help enhancing the quality of the services. During the interviews, staff of VSRs were able to elaborate on their functions and approaches applicable in responding to GBV cases. Registration and handling of client`s information within VSRs needs further improvement. The responsible personnel at VSRs register incoming clients in a unified manner according to the registration card endorsed by the MoHSP but it differed by VSRs, in some cases the data is inconsistent and not comparable across different locations. The responsible staff of VSRs have established strong partnerships locally with existing services for victims of gender-based violence i.e. psychological and legal support within the local branches of Committee on Women and Family Affairs, NGO-run crisis/resource centers for women funded through other international donors and existing gender sensitive police units where inspectors on response to domestic violence are available. Given the strong and long presence of NGO-run services for victims of DV and other forms of GBV in the country, it is rational to increase inclusion of NGOs in the UNFPA

activities on strengthening multi-sectoral response to gender-based violence along with relevant state institutions.

CO in cooperation with UNFPA Regional Office and Eastern Europe Institute on RH supported introduction of Standard Operation Procedures (SOPs) for health, police and psychosocial services in Tajikistan. Multi-sectoral cooperation platform to response to GBV is established within current CP consisting of Ministry of health and social protection, Committee of women and family affairs and Ministry of internal affairs. SOPs are introduced to MSCR team. Recently the MoHSP have adopted SOP for health in state language and it needs to be integrated into health education and services.

MSCR team conducted regular monitoring, exchange visits to VSRs, and conducted advocacy meetings based on findings and outcomes of visits. This activity forced MSRT to find out missed opportunities within the Law on prevention of violence in the family and initiate revision process. The Government of Tajikistan created three technical groups for revision of current Law including one in CoWFA, second in General Prosecutor Office and third in Ministry of justice (this is ongoing).

UNFPA organized cross visits for multisectoral actors working on GBV prevention and response has positively contributed to strengthening GBV referral network. Staff of VSRs in respective locations, relevant staff of CoWFA and police all mentioned the cross visits and monitoring as a strong channel which provided an opportunity for them not only to learn from the work of specialists in other locations, but better organize the referral within their district and locations once they were introduced to each other and immersed in a joint learning experience. This approach strongly contributed to creating multi-sectoral cooperation response team at those levels where VSRs are functioning.

The “Guidance on strengthening of health sector response to gender-based violence” and SOPs for health professional adopted by MoHSP, promoted by UNFPA, are essential tools for enhancing SRH service provision to victims of GBV. Availability of these guidelines and SOPs are critical for strengthening the referral system as well. During interviews staff RH centers were giving information on attended trainings and other UNFPA capacity building activities on engagement with gender and GBV work. However, recently adapted SOP for health need to be introduced to RH centers at different levels.

UNFPA supported a number of studies and surveys on gender inequalities in line with SDG indicators. The findings of these surveys are incorporated into programme planning, CEDAW reporting and revision of policy frameworks on gender. It was found out that district women committee authorities are not well informed on international treaties and CEDAW recommendations. Thus, CP in the frame of RRF supported the CoWFA with localization of CEDAW national plan of action at the district levels of Khatlon and Sughd provinces. CPE team noted that most development processes in all spheres (economic, social) are undertaken in the capital and regional centers and rural areas are less benefitted from these processes. It is also documented in the National Reporting on SDG implementation (2018).

UNFPA was the first organization to introduce an effective innovative approaches such as Public Health Fairs in the country – qualified specialists and professors from capital and regional centers came to remote villages and provide gender sensitive, quality health and legal services to the population of remote rural areas including providing services to furthest behind – migrants’ wives and daughters, people with disabilities, young mothers and poor population who was not able to reach these services by qualified experts. Notable remark CPE team made is that young girls and mother in laws were also visiting these PHFs. This helped experts to advocate and increase their awareness on prevention of early and forced marriages, complications of early pregnancies, following inter-birth interval, promoting rights of young girls and mothers to education, prevention of cervical cancer etc. One of visited Rural health center staff mentioned that: *“When we informed our population about a visit of qualified experts from capital to this rural health center, they were very happy as most of them are from poor families, their husbands, sons are in labor migration and they cannot allow them to go to regional center or capital for qualified services. During this health fair all population of our territory came to use services of qualified specialists. This was very effective considering population perception and bringing services close to the*

population. We have a growing number of divorces among young couples. Experts worked with mothers and mothers in law on prevention of early marriages and divorces that are directly linked to GBV in the family". Within each of public health fairs, more than 500-600 women and girls received counseling, health and legal services.

Opportunity to get a qualified legal advice during the health fair also proved important. This initiative bringing services close to the population of remote rural areas created community of educated clients and increased use of health and legal services.

12: The CP has reached most of the targets for its outputs and outcomes in the Population dynamics focus area and is on track for reaching the remaining ones.

Outcome: Strengthened national policies and international development agendas through integration of evidence based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality.

Indicator	Baseline	Target	Actual
Number of new development policies and strategies that address population dynamics by accounting for population trends and projections in setting development targets	1	3	3

Output: Strengthened national capacity to produce evidence and to formulate national policies and strategies that integrate population issues.

Indicator	Baseline	Target	Actual
Number of national specialists trained through UNFPA support in the production, analysis and dissemination of census surveys and other statistical data, including in humanitarian settings.	0	500	590
Number of new conducted population surveys and analysis with UNFPA support that contribute to evidence –based formulation of development policies and strategies.	2	4	9
A functioning tracking and reporting system to monitor implementation of national plans and policies in the areas of demography, sexual and reproductive health, youth, gender equality and humanitarian response.	No	Yes	Yes
Evidence that Population and housing census in 2020 is conducted following internationally agreed recommendations	No	Yes	On track

In 2016 the CP supported development of the 2020 census action plan that includes related budgets, procurement plans, dissemination, pilot census and training needs. In 2016-2018 CP supported a number of training events for the AS specialists who will be involved in conducting the census, including seminars on the use of modern technology and a study tour to Belarus and Russia.

Interviewed specialists of the AS who participated in the training events organized by the CP reported that they got new knowledge and skills, especially related to the use of tablets and internet. According to respondent these skills were successfully applied during the pilot census conducted in October 2018 in Nurek, Khatlon province, and two micro-districts of the city of Dushanbe, as well as in 2019 during pilot population census in two locations in the Sugdhi province.

Specialists trained by the CP shared the new knowledge with colleagues thus increasing the reach of the UNFPA capacity building efforts. The actual number of national specialists trained through UNFPA support in the production, analysis and dissemination of census surveys and other statistical data in 2016-2019 is 590 which already exceeds the CP target of 500. Successful implementation of the pilot census in 2018 suggests that population and housing census in 2020 will be conducted and the corresponding CP output indicator will be achieved.

- **In 2016-2019 the CP has already achieved the target for the number of new conducted population surveys. UNFPA support was instrumental both in terms of building capacity of the staff of the AS to conduct those surveys and technical and financial support to survey implementation.**

In 2016, UNFPA supported conducting of the resource flow survey on the national expenditure on family planning. Survey results were incorporated in global report on Family Planning Resources Flows (COAR 2016). CP also supported training for 16 AS specialists from provincial branch offices on how to conduct thematic surveys.

In 2016-2017 as part of the Labor Force Survey UNFPA supported the survey on migration issues – in partnership with the Statistic Agency and the World Bank. UNFPA supported the development of the migration module as well as data collection, analysis and preparation of report.

In 2017 UNFPA supported implementation of the DHS survey.

In 2018 within the framework of the CRVS project quantitative and qualitative survey on “Assessment level of population awareness and usage of Civil Registration services in Tajikistan” was conducted among the target population in 4 project districts. The survey helped to identify the most effective strategies for raising awareness and promoting the use of civil registration by the population.

In 2019 UNFPA in partnership with WHO conducted a pilot Health-behavior of school-aged children (HBSC) scientific survey in Tajikistan. Today HBSC is the only survey that provides a complete evidence of adolescent health and behavior, which is crucially needed for shaping adolescent health chapter of new Tajikistan NHS 2030.

- **The CP contributed towards establishment of the tracking and reporting system to monitor implementation of national plans and policies in the areas of demography, sexual and reproductive health, youth, gender equality and humanitarian response.**

In 2016 UNFPA – in cooperation with UNICEF - supported upgrade of the TojikInfo online database that allows users to review and analyze poverty levels and social status of population, demographic trends, population health status and social inequality spatial trends (COAR 2016).

- **The CP contributed towards greater capacity of national and regional authorities, including members of parliament, to use demographic data for development of national and regional development programmes.**

In 2016 UNFPA supported the development and delivery of trainings based on the “Population Handbook” that reached 34 regional specialists responsible for regional development programs. In 2016 UNFPA supported members of the National Population and Development Committee under the Parliament of Tajikistan by making a presentation on the main population and development concepts and on emerging population issues. In 2017 UNFPA supported a member of Tajikistan Parliament to attend the demographic courses hosted by Higher School of Economics in St. Petersburg, Russia.

- **The CP has already achieved its target for a number of new development policies and strategies that address population dynamics**

In 2016 UNFPA contributed to the development of the National Development Strategy for 2016-2030 and the national mid-term development strategy for 2016-2020 by providing recommendation on population issues. In addition, UNFPA provided valuable inputs on development of the National DRR Strategy 2016-2030 to ensure that SRH and Gender specific issues are integrated in disaster and emergency related interventions.

- **In addition, through the CRVS project UNFPA contributed towards improvement of the national CRVS system through improved regulation and technical capacity as well as provided direct support with obtaining necessary CRVS certificates to people in remote villages.**

UNFPA contribution to implementation of the CRVS project included:

- Comprehensive assessment of acting laws and regulations to identify existing gaps, especially on statistical functionality of CRVS system. 11 of 29 recommendations that resulted from this assessment were fully accepted by the Ministry of Justice (MoJ), and 2 – partially.
- UNFPA supported the MoJ with the development of a roadmap for implementation of recommendations on the legal and regulatory framework, statistical functionality, data flows and development of information mapping for civil registration system.
- UNFPA successfully sensitized the national authorities (including members of Parliament, staff of the Ministry of Justice and other relevant state agencies) about importance of improvement of the CRVS system. For example, in 2019 it conducted a high-level conference on the CRVS Reform that was attended by 80 high-level public executives from the Executive Office of the President of the RT, MoJ, MoHSP, MoFA, MiA, AS and Local Development Committee. In 2019 high-level officials also participated in the study tour to Georgia to learn about importance CRVS reform and importance of availability of accurate and complete data for development and planning.
- UNFPA also conducted CRVS data flow assessment that identified system, procedural, resource, technological, and functionality gaps, and informed the development of the improvement plan.
- UNFPA also contributed to improvement of birth/death statistics at jamoat level. In 2016 it supported introduction of new report forms for births/death registration and on-the-job-trainings for jamoat specialists responsible for the production of birth/death statistics. As a result, the quality of birth/death statistics improved.
- “Assessment level of population awareness and usage of Civil Registration services in Tajikistan” completed in 2018 informed the training on development of the draft communication strategy on CRVS and “Communication Strategy and Work plan to increase legal education of population on timely civil registration acts” for partner agencies and communication working group of the MoJ. The communication group developed the Draft Work Plan to increase legal awareness of population on civil registration acts in 2019-2020.
- In 2019, the mechanism for monitoring and implementation Communication Plan was developed.
- Information materials were developed on all seven Civil Registration Services: birth, death, marriage, divorce, adoption, affiliation, surname and patronymic.
- UNFPA jointly with MoJ organized mobile consultation to provide CRVS services in remote areas reaching over 4,000 people.
- Media campaign reached about half of the Tajikistan population.
- 160 children (1-16 years old) received birth certificates due to support provided in the course of mobile consultations.

EQ4. To what extent has UNFPA policy advocacy and capacity building support helped to ensure that sexual and reproductive health (including Family Planning), and the associated concerns for the needs of young people, gender equality, and relevant population dynamics are appropriately integrated into national development instruments and sector policy frameworks in the programme country?

UNFPA supported the development of a number of important policy documents in the SRH and Adolescent and Youth areas. UNFPA support was also instrumental for development and adoption of a set of SOPs that regulate comprehensive multi-sectoral response to GBV. UNFPA played a key role in developing national instruments integrating issues of population dynamics.

13: UNFPA supported the development of a number of important policy documents in the SRH area.

A wide range of nationally representative surveys and assessments have served as the basis for the UNFPA Program in developing and implementing activities to meet the needs and expectations of beneficiaries and partners. Stakeholders noted that UNFPA is one of the best examples among development partners, where a situation assessments were carried out before specific activities were tailored to the needs of the beneficiaries and partners (stakeholder interviews).

From 2015 to 2018, more than six separate in-depth studies and evaluations related to reproductive health were conducted: survey on quality of integrated SRH in PHC, assessment of RH/FP in Tajikistan, needs assessment and review on Cervical Cancer prevention, review of Midwifery programme, assessment of quality of care at the hospital sector. These assessments led directly to the development of interventions and protocols for addressing key reproductive health concerns to achieve results. For example the Sexual and Reproductive Health Services Quality assessment (2016) led to the development, approval and introduction of two strategic documents “Strategic plan for the development of family medicine-based primary health care in the Republic of Tajikistan, 2016–2020” and “National Plan of Actions on Reproductive, Maternal, Neonatal, Child and Adolescence Health for the period of 2016-2020”. Based on results of Needs assessment on cervical cancer prevention, the project proposal is developed and funding support received from Japanese HelloSmile Project. Post project implementation review is conducted for analysis of effectiveness of this project and delivering recommendations to the MoHSP on further step. These sequential integrated approaches helped CP to go beyond initial targets and contributed to formulation of SRH policy.

UNFPA contributed towards development of important policy frameworks in the SRH area:

- National action plan on Reproductive health, maternal, newborn, child and adolescence health (2016)
- Health code of Tajikistan (2017)
- Strategic plan for the development of family medicine-based primary health care in the Republic of Tajikistan (2016–2020)
- National Program on SRH for (2019-2022)
- National Communication Strategy on SRH
- National HIV Prevention programme 2018-2020
- National Development Strategy-2030, item: (2) health care.

14: UNFPA supported the development of a number of important regulations and guides in the Adolescent and Youth area.

As a result of UNFPA CO joint advocacy efforts with existing strengthened youth platforms, decree of the Ministry of Education of the Republic of Tajikistan was issued in April, 2017, according to which the national work group (WG) was established to develop the curriculum for teachers and the textbooks for the school children of 10-11 grades on Healthy Life Style Education. The Academy of Education and Teachers` Training Institute have been meaningfully collaborating with UNFPA in ensuring and increasing access of adolescents and young people to sexual and reproductive health education as part of the working group. This has been done through development of HLS modules for grades 10-11 of secondary school students followed by testing of the modules with teachers to contextualize them. Further in 2018, UNFPA initiated a signature of a partnership agreement with the Ministry of Education to institutionalize the HLS subject. UNFPA IP, YPEER has signed Memorandum of Cooperation with Ministry of Education for five years to promote the concerns and needs of young people.

In 2016 UNFPA CO provided technical support to the MoHSP in revision of existed normative documents in the area of adolescence and youth health. In order to increase access of marginalized group to SRH services, amendments were made to the Law on Reproductive Health and Reproductive Rights and follow up regulation document “The procedure for providing health services and consultations on reproductive health to adolescence and young people, including representatives of the key pop” was developed and approved by the government.

Such guidelines SWIT, YKP tool kits focusing on the specific needs of key population and providing relevant tools for organizations and agencies responding to these needs has been adopted and approved. The guideline has been examined by the Ministry of Health and endorsed for use by relevant institutions and organizations working with key population.

15: UNFPA support was instrumental for development and adoption of a set of SOPs that regulate comprehensive multi-sectoral response to GBV.

UNFPA initiative on strengthening multi-sectoral response to GBV in a consistent manner is very critical given the weak state of coordination between different GBV responders and sporadic initiatives on enhancing collaboration. The multi-sectoral response is a core element in operationalizing domestic violence prevention law. This work has helped to bring relevant actors together in a meaningful and organized manner to increase their coordination when dealing with cases of GBV as well as providing space for advocacy and development of other specific policy instruments. The recommendations of multi-sectoral working group served as a basis for the government to create three working groups on revision of the Prevention of Domestic Violence law. Development and endorsement of SOPs for health sector professionals is a major step in enhancing the quality of services and strengthening the referral system. Promotion and drafting of SOPs for law enforcement and social workers is another important step in gradually achieving the goal on creating effective sectoral response mechanism. Youth friendly centers face challenges with law enforcement structures when dealing with teen pregnancies or cases of GBV involving adolescents. The country's laws and regulations require staff of YFCs to report these types of cases to law enforcement and breach the confidentiality principle. Law enforcement needs to be trained on handling these types of cases with increased sensitivity. The concerns and needs of adolescent girls among GBV victims or cases of teen pregnancies should be explicitly covered in the SOPs on responding to GBV for law enforcement that are in the process of enrichment and adoption.

Mainstreaming gender sensitive approach in humanitarian and emergency context has been done through adaptation of SOPs for Prevention and Response to Gender-Based Violence in Emergencies based on reached agreement between UNFPA and MoHSP in 2016. The Thematic SRH WG in crisis established under the decree of MoHSP in 2016 developed the Clinical Protocols for Rape Survivors as part of the Minimum Standards for Prevention of GBV in emergencies within the Minimum Initial Service Package for SRH in Crisis being rolled-out nationwide.

16: UNFPA played a key role in developing national instruments integrating issues of population dynamics.

According to interviewees with national partners involved in the development of below mentioned documents concerning population dynamic, UNFPA played a key role in developing national instruments for population dynamic by supporting capacity building. UNFPA become initiator of ensuring sexual and reproductive health (including Family Planning), and the associated concerns for the needs of young people, gender equality, and relevant population dynamics. Due to improved capacity building among civil servants of government institutions following Strategies, Law, Concept, Program were designed:

- **National Development Strategy for 2016- 2030** which is the main focus of SDGs is the concept of Sustainable human development. Therefore, complete eradication of poverty, replacement of unsustainable and promotion of sustainable consumption and production patterns, as well as protection and sustainable use of natural resources to ensure further economic and social development are the main objectives and key factors of sustainable human development. (NDS 2030).
- **Medium-term Development Program for 2016- 2020** where mentioned that government activities of country present time and future would be directed for achieving strategic aims: 1) Ensuring energetic safety and effective use of electricity; 2) Exiting from communication deadlock and converting country for transit; 3) Ensuring food safety and access population for qualitative nutrition; 4) Broadening productive employment. Without realization these aims, to achieve SDG (Sustainable Development Goals) approved in 70- session of General Assemble of UN in 2015 it is impossible. There are 6 key problems concerning population dynamic like improving demographic data, capacity building, increasing awareness of population concerning family planning and others finding their solution.
- **State Youth Policy Strategy in the Republic of Tajikistan till 2020**
- **Law concerning "Compulsory medical examination for youth before marriage" (for the purpose of detection of possibility to be pregnant and AIDS**
- **Concept of family development (2016).**

- **2017 Demographic and Health (DHS) Survey: UNFPA provided technical support to the second DHS Survey in Tajikistan, undertaken in collaboration with the Statistical Agency.**
- **State Programme on RH for 2019-2022:** This program is developed to promote family planning, increase accessibility, quality and efficacy of reproductive health services for population, primarily focusing on youth. The Programme intends to improve women's health, educate in sexual ethics, involve the Development partners, civil associations and private sector to ensure funding of educational institutions, healthcare facilities with modern equipment and technologies and contraceptives are equipped. It also intends to train health workers in reproductive health, strengthen contraceptives supply and distribution management, develop information and education materials, raise population awareness and knowledge in the reproductive health issues.

17: UNFPA cooperation with the National Population and Development Committee under the Parliament of Tajikistan contributed towards acceleration of ICPD PoA and SDGs.

CO has built a strong advocacy channel at the Parliament level and supported establishing the National Population and Development Committee (NPDC) consisting of parliament members and high-level senior authorities from all line ministers (17 ministries). CO closely worked with NPDC in accelerating ICPD PoA and SDG goals and advocated for UNFPA mandate and implementation of CPD targets. Joint NPDC and CO advocacy meetings were conducted on SRH, Gender and PD issues. Respectfully, the CPE team should acknowledge important achievements made by NPDC and UNFPA CO. Thanks to continue advocacy and focused joint efforts the Government of Tajikistan created budget line for RH within health sector and started allocation of funds from state budget. President of Tajikistan signed the first costed National strategy on RH with funding support from the state budget. CCP project is recognized and introduced for the first time in Tajikistan. Gender equality is considered within all national strategies and victim support rooms are recognized by NPDC as area of priority and investment. Spotlight programme is presented first to the NPDC as entry point to national high-level authorities. However, in March 2020 parliamentary elections are planned, thus the CO should make every effort and support the functioning of this important advocacy channel for pushing national partners towards achieving ICPD and SDG targets and national commitments made in Nairobi.

Efficiency

EQ5.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 country programme?

CO pursued the achievement of the results defined in the UNFPA country programme despite of lack of human resources by using an adaptive management approaches and strongly contributed to increase of UNFPA visibility in the country and UNCT coordination.

Strategic cooperation with government partners, the National Population and Development Committee under the Parliament and integration with existing national systems and processes facilitated high efficiency of the use of UNFPA financial resources.

18: CO organizational realignment process and staff turnover put additional workload on CO staff. However, CO used adaptive management approaches with proper distribution of workload among staff, maintained strong teamwork and cohesion that allowed the office to achieve CP targets and demonstrate tangible results.

As per CO realignment process, the new organigram retained AR (NOC), Programme Analyst (PA) on SRH&Gender (NOB), PA on Population and Development (NOB), AdminFinance Associate (AFA/G7) and Drivers (G2&SB2) from the previous cycle.

Within realignment process the following new posts were announced and filled with the staff: PA on HIV&Youth (NOA), Programme Associate on SRH (G7), Programme Associate on Communication and Advocacy (CA), Programme assistant (G5), Administrative Assistant (G5). In addition, within donor funds CO recruited Project AFA under SC (SB3).

During the CP implementation period due to career promotion of CO staff to international positions and leaving to other organizations, CO staff have undertaken backstopping functions in addition to their JD to support smooth implementation of CPD delivery. For instance, Programme AdminFin Assistant performed AFA tasks (2016-2017), SRH NPO performed PD NPO (2016) work, HIV NPO performed adolescents (2017-2018) and PD NPO (2017)'s work, Programme Associate on FP/RHCS performed Procurement focal point for RH commodities (UNFPA Supplies) and CP Humanitarian response FP (2016-2019). In the absence of PA on PD (detail assignment in Asia and the Pacific Regional office, duration - September-December 2019), Programme assistant is backstopping this position. Administrative Assistant is performing Programme Associate on CA since September 2019 till present (vacant position, recruitment process is initiated). Since, November'2018 till now, NPO on SRH&Gender is performing the duties of acting AR position.

The office was undergoing re-transformation of personnel and staff turnover to international positions and other agencies, however, the office made every effort to cope with the shortage of staff using the mechanisms of redistribution of workload in agreement with the staff. This demonstrated staff's commitment and loyalty to the aims, principles and purposes of the UNFPA and passion for their work. Strong teamwork and cohesion allowed the office to achieve all CPD targets and demonstrated tangible results.

19: CO pursued the achievement of the results defined in the UNFPA country programme and contributed to increase of UNFPA visibility and UNCT coordination.

For the time being, the UN system organizational reform is ongoing in the world. In Tajikistan, UN Resident Coordinator (RC) office is established as an independent new structure. Former UNDP Resident Representative, UN RC would stay with UNDP as UNDP RR. Recruitment to new UNRC office is completed and vacant positions are filled now. Newly appointed UNRC will start its performance in February 2020. The UNDP RR is performing acting UNRC functions until February 2020.

The UNFPA CO in Tajikistan is managed by an Assistant Representative (AR) under the supervision of the UNFPA Country Director (CD) based in Tashkent, Uzbekistan. CD is responsible and coordinating these two countries providing clear guidance and support in timely and effective delivery of CP. UNFPA as member of UNCT contributed to One UN approach in programme and operational matters. CO was part of number UN joint initiatives and projects, actively contributed to UNDAF planning, implementation, monitoring and reporting. UNFPA made inputs in joint UN and National SDG review contributing and playing important leadership role in Health and Gender sectors.

Observation showed that 2019 was marked as a ceremonial year around the world due to celebration of UNFPA50 and ICPD25. In this context, CO organized and conducted number of high-level events including high level International Forum of Parliamentarians, Forum on launching of the State World Population Report, UNFPA EECA Regional Director, Deputy to Director, Regional Advisors missions to Tajikistan, Forum on World Population Day, Disability Forum, events devoted to 16 days of activism against women etc. CO contributed to review of five out of six UNDAF Outcomes and co-chaired UNDAF Outcome 5 on Gender. UNFPA strongly contributed to design of UN joint Programme "Country Programme Document" under joint EU-UN "Spotlight Initiative (SI)", and was selected as one of Recipient UN agencies (RUNO) and was granted with biggest amount for programmatic activities. CO organized a high level meeting of the National Population and Development Committee under the Parliament of Tajikistan on presentation of SI by UNRC. CO managed with organization of high-level delegation to the Global Summit in Nairobi. The above-mentioned activities significantly increased UNFPA visibility in the country among UN agencies,

development and national partners and contributed to achieving desired CP results that are mentioned in previous sections.

20: Close cooperation with government partners and integration with existing national systems and processes facilitate high efficiency of the use of UNFPA financial resources.

National partners interviewed by the evaluation team noted that UNFPA is making good use of its financial and human resources. *“UNFPA does not have much money. Nevertheless, with these modest funds they achieve many results due to close cooperation with national counterparts. They show us the modest and effective ways in addressing our challenges and needs. They work continuously until achieving results in spite of challenges and barriers they met”*, said one of respondents.

As a result of continues evidence-based advocacy and close cooperation with government partners, the National programme on RH is developed and approved by President of Tajikistan (June, 2019) which is the first costed strategic document in health sector with funding support from state budget. With this, the government of Tajikistan demonstrated political commitment to international agreements and ICPD principles and put platform toward accelerating SDGs objectives.

The evaluation has found out that in delivering some activities, UNFPA financial support to activities (M&E, mentoring, RH campaigns) implemented in partnership with health care system institutions is related to covering travel expenses only (DSAs, transportation cost) of participating national specialists and their service are considered as in-kind national partners contribution. Follow up to UNFPA initiated activities, national partners organized their own campaigns, M&E activities and mentoring/on-job trainings in maternity clinics and RH centers with high maternal death and RH complications using funds from state budget.

21: Use of national mechanisms facilitate achievement of UNFPA strategic results in the Adolescents and Youth area.

One of the intended results of the UNFPA CP 2016-2020 in the Adolescents and Youth focus area is increased availability of comprehensive sexuality education. All efforts undertaken by the UNFPA in the area of HLS is focused more on its institutionalization. Taking into account limited resources, UNFPA committed to cover up to 10% or 325 secondary schools with HLS. Indicator on track and by 2020 it is expected to achieve this 10%.

Taking into account budget limitations in 100% coverage, some efforts done by the CO in mobilizing the other UN agencies, as such UNESCO, UNICEF etc. to increase coverage of secondary schools.

Integration of partnership among relevant government structures is very effective in increasing coverage. As such, collaboration between MoH and MoE is a good example when doctors and teachers are delivering lectures in schools on HLS. Teachers are referring students to Youth Friendly Centers, however, not all students aware of such centers. There is a need to increase awareness among students and schools about YFC and available services.

UNFPA actively use youth platforms, to reach out young people, including students. YPEER, UNESCO club volunteers, YSafe are the platforms that assist UNFPA to promote HLS among young people. Platforms also used to include young SWs and MSMs.

Another mechanism to use, is internet resources. YPEER developed with support from UNESCO and UNFPA a web site that provide visitors, mostly youth with competent information on SRH and HLS, including sexuality, GBV, etc.

In 2019 UNFPA lead a regional technical meeting under the MoE leadership on HLS where recommendations were developed. As a result MoE came up with a road map on implementation of those recommendations.

EQ6. To what extent have the partnerships established with ministries, agencies and other representatives of the partner government allowed the country office to make use of the comparative strengths of UNFPA, while, at the same time, safeguarding and promoting the national ownership of supported interventions, programmes and policies?

The evaluation has found that UNFPA is consistently using approaches that promote national ownership of supported interventions including: (i) regular consultations with stakeholders; (ii) building on national systems and processes, (iii) advocacy and supporting dialogue between national stakeholders on developing policy frameworks and strategies based on ICPD and SDG principles; and (iv) national execution of supported interventions; (v) UNFPA focused on long-term results and sustainability by integrating international standards and evidence based programmes into national policy frameworks, strategies and educational programmes.

22. UNFPA conducted strong advocacy and supported dialogue between national stakeholders on developing policy frameworks and strategies and integrating ICPD and SDG principles for sustainability of the programme.

According to UNCT members interviewed by the evaluation team one of the strengths of the UNFPA CO is its ability to maintain a **balance between pursuing its mandate and ensuring national ownership** of its work.

OECD-DAC defines national ownership as “the effective exercise of a government’s authority over development policies and activities, including those that rely – entirely or partially – on external resources. For governments, this means articulating the national development agenda and establishing authoritative policies and strategies. For [aid] donors, it means aligning their programmes on government policies and building on government systems and processes to manage and coordinate aid rather than creating parallel systems to meet donor requirements”⁴⁸.

CP used RBM principles and focused on long-term results and sustainability of programmes. New Policy frameworks and strategies described in Findings #13 and #16 are developed in line with international standards and evidence based programmes that are supported within current CP. Confirmation of this, Reproductive health and rights chapter of the Health Code (2017) was reviewed and updated with CO strong advocacy according to UNFPA Regional Model Law on RH&Rs promoted by UNFPA EECA Regional Office. Thanks to implementation of UNFPA EECARO promoted multi-sectoral cooperation response system within UN Global essential service package and SOPs, revision of the Law on prevention of violence in the family is initiated with CO support. International standards on gender equality, GBV prevention, services in line with ICPD and SDG is promoted in revision of the Law (on going). Additionally, worth to note that CP supported new regulation “The procedure for providing health services and consultations on reproductive health to adolescence and young people, including representatives of the key pop” created political foundation for sustainability of UNFPA supported activities in youth and adolescence health.

23: The evaluation has found that UNFPA is consistently using approaches that promote national ownership of supported interventions including: (i) regular consultations with stakeholders; (ii) building on national systems and processes, (iii) supporting dialogue between national stakeholders; and (iv) national execution of supported interventions.

- **Regular consultations with stakeholders**

⁴⁸ OECD, 2006, DAC Guidelines and Reference Series Applying Strategic Environmental Assessment: Good Practice Guidance for Development Co-operation, OECD, Paris. <https://stats.oecd.org/glossary/detail.asp?ID=7238>

The evaluation has found that Tajikistan authorities demonstrate a high level of commitment to the national development agenda, especially in the health sector. For example, the national parliament closely oversees the implementation of the National Health Strategy 2010-2020, especially situation with MMR and child mortality. The MoHSP has established the Development Partner Council to coordinate donor efforts. The Council meets on a monthly basis to discuss the progress of the projects and intervention supported by the partners. Sites to be targeted by donor interventions are usually determined based on the administrative statistics collected by the MoHSP. In addition, UNFPA holds annual review and planning meeting with the national stakeholders.

The evaluation data indicates that UNFPA being open to ideas emerging from consultation with national partners contributes towards greater ownership of planned interventions. For example, in 2016 national partners discussed possible UNFPA support to improvement of the SRH services provided by the primary level health institution in line with the *National Health Strategy 2010-2020* and *Plan for the development of primary medical and social services using family medicine model 2016-2020*. The Republican Training and Family Medicine Center suggested to start with doing the assessment of the quality of SRH/FP/MH/GE services provided by the primary health care centers conducted by the Republican Training and Family Medicine Center. UNFPA supported the initiative and survey is conducted by the staff of this Institute in 2016. Data collection instruments were based on WHO assessment tool. Assessment covered provision of family planning services, antenatal care, services to adolescent, prevention of STIs and HIV, prevention of cervical cancer, prevention of GBV. Results and recommendations of this assessment were presented to the MoHSP and development partners leading to the development of the national action plan. Based on findings of this assessment the MoHSP and UNFPA addressed the existing challenges during planning for 2017-2019 toward achieving CP RRF.

Within the framework of the intervention that aimed to promote integration of service for key populations (SWs and MSMs) from NGO to government health sector stakeholder consultations were used to develop a road map for the integration process. Intervention included delivery of three advocacy and service integration workshop for NGOs working with key populations and three workshops for family doctors on service provision to key population. UNFPA and an implementing partner allocated part of the time during these workshops for consultations with stakeholders to get their ideas and recommendations that formed the basis for the forthcoming road map. The draft of the road map was submitted to the MoHSP for further consultations.

All training materials developed with UNFPA support become effective only after approval by the relevant national stakeholders.

- **Building on national systems and processes**

Majority of UNFPA capacity building interventions target already existing national institutions and systems: primary health care system, reproductive health care system, maternity clinics, the system of Training and Family Medicine Centers, midwifery education system, school system, civic registry system and the national statistics system. UNFPA also supported building of institutional capacity of already existing national NGOs and supported their networking.

Even when UNFPA was supporting the newly established structures, these structures were usually established on the bases of already existing institution. For example, in 2018 the Ministry of Justice established a working group responsible for development of the CRVS-related communication strategy. (The group was institutionalized by the decree #99 from July 18, 2018.) UNFPA supported operation of this group within the framework of the CRVS project by providing results of an assessment of the capacity the Ministry of Justice to disseminate civil registration information among population and training “Communication Strategy and Work plan to increase legal education of population on timely civil registration acts” for group members.

- **Promoting dialogue between national stakeholders**

UNFPA is consistently supporting round tables and cross visits to promote dialogue and exchange of experience between national stakeholders. In many cases, these activities are seamlessly integrated in UNFPA support targeting some specific issue.

UNFPA CO supported regional advocacy meetings on ICPD and SDGs promoting reduction of maternal mortality and reducing unmet needs for family planning involving 280 health managers from 72 districts of Sogd and Khatlon provinces, which led to increase of commitment of local managers to SRH, MH, FP and HIV prevention.

Meetings have already led to greater awareness among health managers about importance of SRH, FP, MH and HIV testing among pregnant women to prevent mother to child transmission and their commitment to ensure availability of testing. In the past UNFPA supported the national partners with provision of HIV rapid tests for pregnant women from UNFPA Supply Funds as a temporary assistance. However, thanks to UNFPA evidence based advocacy the MoHSP started allocation of some funds to cover this need. State funding is not sufficient to ensure uninterrupted supply of HIV express tests to health facilities. To resolve this problem district managers have started doing their own fundraising from local state funds to purchase HIV express tests and ensure consistent access to HIV testing of pregnant women in their districts.

To achieve universal access to quality FP information and services, UNFPA and the Ministry of Health and Social Protection (MoHSP) of Tajikistan agreed to develop and implement interlinked strategic course of action. The immediate need was to close the financing gap of contraceptive supply to ensure availability of a range of FP methods but it was felt that it was also important to make the National FP programme stronger in order to close the unmet needs. To achieve both strategic objectives, advocacy interventions were made together with the National Committee on Population and Development made up of the Parliamentarians, key Government ministries and the media to the Government of Tajikistan (GoT) to create a budget line and start allocating the state budget for contraceptive procurement and to develop a new State Programme to strengthen FP programme being an integral part of the comprehensive National Action Plan on Reproductive, Maternal, Newborn, Children and Adolescence Health 2016-2020.

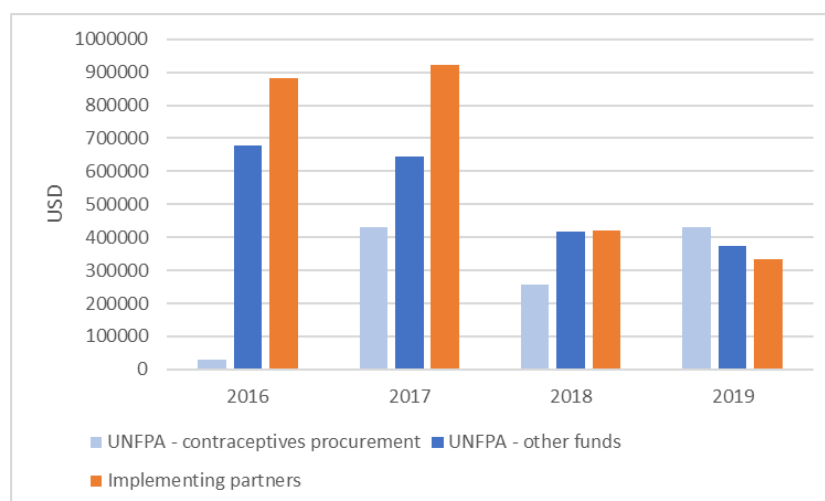
Another example, in 2017 UNFPA supported assessment of the accessibility and quality of SRH services provided to SWs and MSMs by primary health level institutions. Assessment was conducted by the Republican Training and Family Medicine Center. UNFPA CO and NGOs working with these groups helped with the development of the questionnaire that was used to collect information from the staff of the primary level health institutions. Assessment revealed that medical staff was poorly informed about HIV transmission paths, stigmatized SWs and MSMs, and had poor skills in the area of pre-test counseling and overall work with key populations.

During the field visit to the city of Khujand, Sugd province, the evaluation team was able to observe the round table organized with the CO support. The round table brought together state HIV centers and NGOs providing services to key populations (SWs and MSMs) and provided them a venue for discussion of existing challenges and possible solutions. One of the themes that emerged from the discussion was that the tradition model when use of services is stimulated by offering lucrative gift set in exchange for taking HIV tests cannot be sustained without donor funding and promotes dependency of SWs and MSMs from service providers rather than conscious responsibility for one's health and well-being. Given that neither health system nor donor would be able to ensure universal coverage of key populations if the same model continues to be used, it is important to look for different approaches.

- **National execution**

Evaluation data indicates that though the amount and share of the CP budget executed by the national implementing partners was progressively declining (Fig. 10), UNFPA was consistently expanding the pool of national implementing partners while maintaining national execution through the MoHSP and the AS as well as NGOs TFPA and Apiron (Table 12).

Figure 10. Share of the CP budget implemented by UNFPA and its implementing partners in 2016-2019*.



*Data for 2019 is for the period January-September.

Table 12. Involvement of national partners in the implementation of the CP: Number of CP projects where an organization was involved as an implementing partner.

Implementing partner	2016	2017	2018	2019
AS	1	1	1	1
Ministry of Health	5	4	3	3
NGO Gender and Development	1		2	2
NGO Fidokor	1	1		
NGO Apiron	1	1	1	1
NGO Antispid	1			
NGO TFPA	5	4	3	3
NGO Equal Opportunities		1		
NGO ASTI		1	1	1
NGO Hamsol ba Hamsol			1	1
Ministry of education				1

EQ7. To what extent have partnerships built with government or other UN organizations helped to enhance sustainability or scale up interventions and/or bring relevant evidence to policy-makers to adopt such approaches?

In most cases UNFPA operation is not project-based and UNFPA is able to provide long-term continuous support to ensure sustainable implementation and ongoing improvement of the practices introduced with its support. Low operational costs of practices introduced with UNFPA also facilitate their sustainable implementation by government institutions. At the same time high staff turnover, lack of coordination in policy application by national institutions and design of interventions that may affect sustainability on UNFPA supported interventions.

Government institutions organize their internal training events, which contributes towards scaling up the reach of capacity building interventions supported by UNFPA.

24: In most cases UNFPA operation is not project-based and UNFPA is able to provide long-term continuous support to ensure sustainable implementation and ongoing improvement of the practices introduced with its support.

Good example is UNFPA support in the area of **family planning (FP)**. This support started in late 1990s when UNFPA helped Tajikistan to establish its FP system. The evaluation team has met several national stakeholders who were involved in the establishment of this system in late 1990s and they were unanimous that UNFPA support was absolutely crucial. Since then UNFPA was supporting development and sustainable operation of the FP system by providing contraceptives, equipment and instruments, technology (operational standards), building capacity of service providers and strengthening national policy and regulatory frameworks related to FP.

Under the current CP to ensure sustainable operation of the FP system, especially uninterrupted access to contraceptives, and to increase availability of the contraceptive options to women in remote rural communities UNFPA was supporting the government of Tajikistan transition to assuming full responsibility for procurement and distribution of contraceptives (still ongoing), as well as building the capacity and reach of the RH system to provide family planning services.

Since 2015 Tajikistan is no longer eligible for UNFPA contraceptive assistance. UNFPA supported the government to establish a dedicated budget line in the MoHSP budget to procure contraceptives. In order to achieve this, UNFPA and the National Committee on PD made evidence-based arguments on cost-effectiveness of FP services as well as their importance for the country's development (realizing women's potential and making investments in children) and advocated for the state budget allocation. UNFPA also identified a potential donor (Government of Japan) who can contribute to supplement funds from UNFPA and Tajikistan to secure sufficient financial resources to procure contraceptives. This encouraged the Government to allocate state budget and make gradual increase in its budget allocation to demonstrate the national ownership of the FP programme through the USD2.7 mln Joint Project on Strengthening National FP Services for 2017-2020. In parallel, UNFPA and USAID supported situation analysis on FP, the findings and recommendations of which helped to develop a first-ever costed State Programme on RH for 2019-2022 as a state-funded strategy to close the unmet need for FP. The MoHSP and UNFPA also developed a National Communication Strategy for FP as a framework of communication intervention toward the population. The major focus of both strategic papers is reaching young people, who constitute a large proportion of the population in Tajikistan, and ensuring that all communication activities are geared toward common objective of adopting healthy and responsible behavior and increasing voluntary uptake of appropriate FP methods.

UNFPA has also supported strengthening of national logistics information and management system used to distribute contraceptives. In 2017, 20 participants from the selected districts of Khatlon region were trained on the essentials of logistics management and information system for contraceptive distribution, including practical application of logistics software CHANNEL. In 2018 the national system was adjusted based on the results of the review of the existing regulation (MoHSP Order #480 on Logistics Management Information System) and the new regulation was established providing specific roles and responsibilities for PHC and Hospital Managers and RH Center Directors in the management of contraceptive means, guidelines on management of medical and contraceptive means, guidelines on management of warehouses, application of logistics software and etc.

UNFPA has also supported sustainability and greater reach of family planning services, especially to remote areas. In 2017-2019, UNFPA supported training on IUD insertion and removal for 60 midwives working at Health Houses in remote rural communities and two trainings on postpartum contraception for 40 midwives from maternity houses of Sudgh and Khatlon provinces. In 2018, UNFPA supported the development of the clinical protocol on the post-partum IUD insertion. During the field visits the evaluation team has found that both a new protocol and skills gained through UNFPA supported training event are being used.

Another good example is the **use of evidence-based clinical protocols and near-miss case review (NMCR)** by maternal health service providers. These approaches were approved by the MoHSP in 2008-

2012 mainly with advocacy and technical support of UNFPA and further several international organizations joined to this initiative within strategic partnership. Under the current CP UNFPA is supporting sustainable implementation of these approaches. For example, in 2017 UNFPA supported visits of national experts 15 maternity houses of Sugdh, Khatlon and DDRs to monitor implementation of national standards and mentor staff. In 2018 UNFPA supported national coordinators of National BTN Committee to do monitoring and mentoring visits to four maternity houses in Sugdh province to ensure quality use of near-miss case reviews. National conference on launching of the second National Report of NMCR is conducted in 2018 with UNFPA support. This experience is presented in WHO/UNFPA International conference in Bishkek by national team of coordinators. UNFPA is also supporting annual meetings of staff of maternity clinics using near-miss case reviews. According to members of near-miss case review committees interviewed by the evaluation team, while they fully own the near-miss case review and use it consistently, monitoring visits and meetings are crucial for sustainability of NMCR use because they facilitate experience exchange and reinforce motivation. Annual meeting are also reportedly used to expose representatives of new maternity clinics to NMCR and thus promote its broader use in the country.

Yet another good example is sustainable operation of **gender-based violence victim support rooms (GBV VSR)**. Eight rooms were established with UNFPA support at regional and district maternity clinics in 2013. Operation of VSRs are fully institutionalized by the MoHSP orders, clinics keep official records of service provision, including identification of the types of violence a woman using VSR was subject to. Clinics have designated staff in charge of VSR operation (but no designated job positions) and cover operational expenses, mostly food, bed, clothes and medicine from clinic budgets.

The evaluation has found that heads of host maternity clinics are committed to support VSR operation. They regularly promote availability of VSR through mass media. One of the host hospitals have reported to the evaluation team that when the demand for VSR use exceed its capacity, they put BGD victims to regular hospital wards. In one the clinics women using VSR were offered professional training (on sewing) and landing jobs, including at the host clinic. Clinic heads are also using their contacts with the staff of the primary health care facilities and reproductive health centers throughout the province to ensure that they follow with a woman when she leaves the VSR.

Heads of visited host clinics reported that in the framework of the current CP UNFPA supported their participating in cross visits on gender equality, which was useful in terms of exchange of ideas, and making VSRs more welcoming and comfortable for women and their children. As per information of National RH Center 860 victims of GBV were served by eight VSRs in the period of 2012-2019.

25: Low operational costs of practices introduced with UNFPA facilitate their sustainable implementation by government institutions.

The above example of sustainable operation of VSRs is a good illustration of a common pattern emerging from the evaluation data. Institutionalization of a practice/service introduced with UNFPA support through national regulations, including accountability of service providers to the relevant ministry, does not automatically translate into allocation of designated funding to support service provision. As a result only practices/services that can be implemented with no or low additional expenses become sustainable.

CO approached EPC technology as one of cost effective, internationally recognized programme that was most relevant to Tajikistan context considering insufficient funds in health sector.

Implementation of near-miss case reviews at the level of maternity clinics does not involve any financial costs for a clinic and many of the NMCR recommendations are implemented at a relatively low cost. This is one of the factors that explains why the evaluation team has found many cases of sustainable use of NMCR. At the same time the evaluation team has observed that the second part of Beyond the Number initiative on confidential review of maternal deaths has become less organized due to lack of management by the National Association of Ob/GYNs because of frequent staff changes in the Association board (who is responsible for audit of maternal death), lack of knowledge of new comers.

Renewed Association lacked partnership with development partners. In addition, specialists who were given the task to conduct reviews had to do it on top of their regular functions. However, more importantly, the review involves travels and making copies of multiple documents, and these expenses were not covered by the state budget.

UNFPA's lead economic analysis on effectiveness of procuring contraceptives through UNFPA for policy-decision makers, resulted with the decision of the Government to procure contraceptives through UNFPA Procurement services at relatively low prices that has also reduced both operational and market provided costs.

HLS course introduced to schools under Adolescents and Youth component of the CP is based on the interactive training methodology which involves use of flipcharts and markers. Some teachers have reported to the evaluation team that schools don't have funds to purchase these materials. As a result, some teachers don't use the methodology. Those who do buy materials themselves or solicit support from parents (both money and in kind).

Still regulatory institutionalization of practice/service in maternal health introduced with UNFPA promotes both its sustainability and scale up through support of other development partners. For example, USAID Feed the Future Project (2017-2019) supported quality implementation of clinical protocol and NMCR in maternity clinics in six districts of Khatlon province. New JICA Project for Improving Maternal and Child Health Care System in Khatlon Oblast Phase 2 plans to support use of NMCR in another six districts of Khatlon province.

26: Factors that affect sustainability on UNFPA supported interventions include high staff turnover, lack of understanding in policy application by state institutions

In addition to the lack of designated state funding, the evaluation has found several other factors that affect sustainability of introduced practices/services. One is **high staff turnover** in the state sector. For example, as a result of the cervical screening pilot project every health facility in the two target districts had a specialist (a doctor, a midwife or a nurse) trained to do screening. The project was completed in 2018. In the fall of 2019, one year after the project completion, this evaluation has found that in one of pilot districts about 30% of trained midwives and nurses have already left. In the opinion of interviewed national stakeholders, staff turnover is one of key reason for insufficient implementation of NMCR in some hospitals. The same situation is observed in district RH Centers that trained doctors are leaving for labor migration to Russian Federation.

Lack of coordination in policy application by state institutions can also be a reason for undermined sustainability of results of UNFPA interventions. The evaluation team has found that in the end of 2018 MoHSP issued instruction that any surgical manipulation can be provided only if a patient has been recently tested for HIV and hepatitis. This is also resulted in IUD insertion that women who want to have IUD inserted have to take HIV and hepatitis tests for a fee of 90 somoni. This becomes a serious barrier to many women already leading to reduced use of IUDs. However, National RH Center could not provide any evidence on this instruction that is mean that there were no Order by MoHSP. This need to be studied in the future, as there are different opinions among services providers on relevance of mandatory pre-IUD testing to HIV.

The evaluation data also suggests that design of interventions supported by TGF under the HIV prevention component indirectly may promote dependency of beneficiaries on service provision which undermines sustainability on the long run. For example, to motivate key pop for HIV test, people were stimulated by food packages. Representative of SWs and MSMs interviewed by the evaluation team were deeply disappointed that their "privileges" were removed when the project ended and were not ready to use regular services offered by the state which are not free of charge. This pattern was discussed at the round table in Khujand that the evaluation team was able to attend. In the course of this discussion one of NGO representatives commented that the project might have avoided building dependency pattern if it had paid more attention to promoting the feeling of self-responsibility for one's health among targeted key populations from the very beginning. UNFPA is a recipient only and this

concern was communicated to donor. It is recommended to discuss this during next round of TGF funding.

27: Government institutions organize their internal training events, which contributes towards scaling up the reach of capacity building interventions supported by UNFPA.

The evaluation has found examples when government partners scale-up the reach of capacity building interventions supported by UNFPA. The AS is organizing internal training events for staff of its district offices to disseminate knowledge and skills related to census implementation gained by the staff of its regional offices through training organized by UNFPA CP. Sustainability of these capacity development efforts are also undermined by high staff turnover because of low salaries.

Medical specialists also reported to the evaluation team that they share knowledge and materials obtained at UNFPA supported training events with colleagues. Some district level RH centers and maternity clinics organize regular training for the staff to ensure proper use of national standards and protocols, including those developed with UNFPA support.

One of the teachers who participated in HLS training reported to the evaluation team that she delivered demonstrations of HLS sessions attended by teachers from remote locations who were not involved in the project. Visits were organized by regional authorities. A deputy principal in charge of extracurricular education reported that after attending HLS training supported by the CP she organized HLS training at her school for all class coordinators.

UNFPA CP coordination with UNCT

EQ8. To what extent has the UNFPA country office contributed to the functioning and consolidation of UNCT coordination mechanisms?

In 2016-2019 UNFPA CO participated in and contributed to all UNCT coordination mechanisms, including Operations Management Team, Theme Groups, UNDAF Result Group, REACT, Spotlight initiative. UNFPA CO contribution is recognized by other agencies and RCO.

28: In 2016-2019 UNFPA CO participated in and contributed to all UNCT coordination mechanisms, including Operations Management Team, UN Communication Group, Theme Groups, UNDAF Results Group, REACT, Spotlight Initiative. UNFPA CO contribution is recognized by other agencies and RCO.

The evaluation has found multiple examples of the UNFPA CO active involvement and contribution to functioning and consolidation of UNCT coordination mechanisms. For example, in 2016 when UNFPA chaired the **Operations Management Team** it initiated the development of the UNCT business operations strategy, harmonization of activities between UN Agencies, and analysis of the state procurement system.

UNFPA was one of the initiators of the **Youth Theme Group** established in January 2013 and co-chaired the group. In the opinion of the UNCT members due to UNFPA strong leadership the YTG used to be very active and instrumental in terms of initiating joint activities, like celebration of the International Day of the Girl Child, World AIDS Day etc.

Along with UN Woman UNFPA continues to co-chair **UNDAF Result Group 5: Inclusion and Empowerment of Vulnerable Groups**. In this capacity, UNFPA was instrumental in preparation of the National VNR, UNDAF Joint Reporting and Planning. UNFPA is also a member of Result Groups 1, 3, 6 and M&E RGs.

UNFPA is involved in partnership and joint programming with other UNCT members. In the course of the current CP UNFPA contributed towards implementation of four **joint projects**:

- “Support to Civil Registration System Reform in Tajikistan” implemented in partnership with UNDP (that is a lead agency implementing this project) and UN Women with financial support of the SDC; and
- “HIV Prevention among Sex Workers (SW) and Men Who Have Sex with Men (MSM) in Tajikistan” implemented in partnership with UNDP (a lead agency for this project) and funded by the Global Fund.
- The joint Project “Empowering Rural Communities with Better Livelihood and Social Protection” is implemented by five UN agencies – UNDP, UNICEF, UNFPA, UN Women and UN WFP (2013-2016) that was funded by the United Nations Trust Fund for Human Security.
- UBRAF project (UNFPA/UNDP/UNIDC/UNICEF/WHO) implemented by 5 UN agencies in the HIV prevention area since 2016.
- UNFPA contributed to UN Joint project of UNFPA, UNICEF, WHO with the MoHSP on “Strengthening of MCH in pilot district of Khatlon province”. The project approved by the Government and donor.

UNFPA CO demonstrated strong commitment and activism in development of new UNCT Country Programme under EU-UN Spotlight Initiative. UNFPA became one of RUNOs (Recipient UN Agency) and received a large portion of funds.

UNFPA also contributed to the development of Resilience and Vulnerability Atlas led by UNDP.

UNFPA is **facilitating contribution of UNCT members towards the Population and Housing Census 2020**. In June 2019 UNFPA convened a round table that presented Census 2020 potential in terms of measuring SDGs indicators, including capturing data on such complex issues as statelessness, migration and disability. As a result, several UNCT members expressed interest to support the Census 2020⁴⁹ (UNFPA (2019). Advocacy campaign allows to UNFPA mobilized UNHCR resources (in total USD100,000), USD35,000 in 2019 and USD65,000 in 2020, by including into census questionnaire ‘statelessness’ sub-question. In addition, WFP initiated training on Geographic Information System (GIS) to build capacity of AS on mapping for census needs, by providing in-house expertise in this field.

UNFPA also plays an important role in UNCT **joint advocacy efforts**, e.g. 16 Days of Activism Against Gender-Based Violence campaigns, WPD, Orange Day, International Girl Day, IYD, WAD etc.

UNFPA added value

EQ9. What is the main UNFPA added value in the country context as perceived by UNCT and national stakeholders?

In the context of Tajikistan UNFPA added value stems from its thematic leadership in the SRH, especially maternal health and family planning, population and development and long-term consistency of UNFPA support combined with responsiveness to the needs of national context and priorities and operational flexibility.

29: In the context of Tajikistan UNFPA added value stems from its thematic leadership in the SRH sector, especially maternal health and family planning, population and development, long-term consistency of UNFPA support combined with responsiveness to the needs of national partners and operational flexibility.

⁴⁹ UNFPA (2019). Report on the Round table “Population and housing census 2020: advocacy and resource mobilization”, June 2019

In the opinion of **UNCT members**, UNFPA added value comes from its thematic leadership, especially in the SRH including maternal health and family planning, population and development agenda, and its ability to maintain a balance between pursuing its mandate and ensuring national ownership of its work.

For **national stakeholders**, UNFPA added value comes from continuity of its efforts. Unlike many other development agencies UNFPA does not do standalone projects, but provides continuous support for achieving long-term and sustainable results in the areas that fall under its mandate: e.g. UNFPA has been supporting the development of the Tajikistan family planning system since 1998, reorganization of mother and child system according to Effective Perinatal Care and Beyond the Number programmes (near miss cases review), use of standards and protocols to reduce maternal mortality – since 2008, development of first-ever costed State Programme on RH for 2019-2022.

UNFPA is a leading agency on data and statistic issues that is recognized by all UNCT and RCO. Thus, UNFPA is appointed as a led RUNO for 5th pillar “Data management” of Spotlight Programme.

Responsiveness to the needs of national partners and **flexibility** is also seen as UNFPA added value by national stakeholders:

- “They hear us. There are development partners with a rigid mandate. UNFPA had a broad mandate and they are open to our needs” (National partner).
- “UNFPA was always responsive to our needs, and they were able to respond promptly, to the extent that they changed their annual work plans” (National partner).
- “UNFPA CO is very friendly and flexible” (Implementing partner).
- “UNFPA staff is involved in all activities we do. They come to all events we do and we can always come to see them if there are any problems. They hear us” (Implementing partner).

Health management authorities consider UNFPA as results-oriented organization who bring innovative ideas and evidence-based programmes to the country. They trust UNFPA in introducing these new approaches and believe that “*if UNFPA start something new than all other development partners follow them and we know it is long term actions towards achieving results*”. Some national stakeholders have commented that UNFPA added value stems from its leadership in the areas of maternal health and family planning. Many national stakeholders perceive UNFPA as the only agency that supports maternal health and family planning.

CHAPTER 5: Conclusions

5.1: Strategic level

Conclusion 1: UNFPA CP is well aligned with national priorities of Tajikistan, UNDAF results and National Development Strategy, UNFPA strategic areas, ICPD and SDG objectives, addressed country needs by introducing innovative approaches and focusing on needs of vulnerable groups using an adaptive management approach.

UNFPA consistent long-term support to strengthening existing national systems and processes. Focus on national execution facilitated effectiveness of UNFPA support, sustainability of results and efficient use of UNFPA resources.

CO used an adaptive management approach considering availability of resources (human, financial) in pursuing CP results relying on evidences of situation analysis and needs assessments; plans are developed based on that and implemented carefully and monitored. This approach facilitated high degree of alignment of UNFPA support with national priorities and high national ownership of supported interventions.

UNFPA support has a focus on reaching the furthest behind, which is one of key principles embedded in UNFPA strategic plans. This achieved through introducing innovative approaches to increase the access of vulnerable groups to SRHR and legal services. Thus, a coherent and comprehensive approach to the implementation of the CP all together contributed to achievement of results beyond the initial CP targets.

Origin: EQ-1, EQ-2, EQ-3, EQ-5

Conclusions 2: In the frame of CP results, CO made special focus on policy dialogue and evidence based advocacy involving all relevant political and social channels, cooperating with UN and non-UN Agencies that resulted in achieving CP targets and increased UNFPA visibility in the country. UNFPA maintained strong strategic partnership towards achieving three transformative goals by advocating for development and approval of new policies and strategies and mobilizing additional resources.

Strategic partnership was critical in having a harmonized approach of complex issues. The achieving CP RRF became successful because of cooperation and leveraging resources of national and international partners and the proper allocation of responsibilities and resources, promoting One UN approach (UNCT, SMT, GTG, OMT, CG, UN thematic group on HIV, DCCH, DCCE), joint planning/programming and reporting (eg: UNTFHS, GF/UNDP, UBRAF, SDC, EU-UN SI, etc.). In some programmatic areas (SRH), CO supported good practices related to joint sectoral annual reporting and planning (JAR on Health) by the Government and Development partners. These approaches reduced the cost and burden of implementing complex initiatives and increased mutual accountability for results.

Coordination, UNFPA evidence-based and continues advocacy was important in policy and strategy development for introduction of new approaches which is resulted in achieving CP results but it needs to be continued considering high staff turnover and frequent government reshuffles. UNFPA's experience on establishing and working with the National Population and Development Committee under the Parliament of RoT was effective on acceleration of ICPD and SDG targets. For the first time of realization of ICPD in Tajikistan, the Government of Tajikistan approved costed National Programme on RH with national budget and created budget line for SRH. UNFPA practiced triangular cooperation for the first time of presence in Tajikistan involving government funds. Upcoming political trends (Parliamentarian elections) in 2020 and changes in the composition of NPDC require further advocacy work for sustainability and functionality of this important political tool. The CO Communication and Advocacy strategy/plan need to be developed to strengthen CO strategic partnership with traditional and non-traditional donors.

Origin: EQ-1, EQ-2, EQ-3, EQ-4, EQ-6, EQ-7, EQ-8

5.2: Programmatic level

Family planning

Conclusion 3: UNFPA support was crucial in terms of ensuring uninterrupted supply of contraceptives and access to contraceptive by women in remote areas. However, still reduced funding has already led to unavailability of contraceptive implants due to their relatively high costs. This runs counter to the Framework of Actions for the follow-up to the Programme of Action of the International Conference on Population and Development Beyond 2014 which says that “The availability and accessibility of the widest possible range of contraceptive methods, including emergency contraception, with adequate counselling and technical information, to meet individuals’ and couples’ contraceptive needs and preferences across the life course, are essential for reproductive health and reproductive rights”⁵⁰.

Origin: EQ2-EQ3-EQ4

CO shall request UNFPA HQ to reconsider Tajikistan eligibility for contraceptives support in view of reduced income status of the country and to support further contraceptive security roadmap toward state-funded National FP Programme. UNFPA and MoHSP should continue addressing rights-based interventions on FP and hidden issues specifically faced by the poor and vulnerable groups through stronger policy advocacy and lobbying for FP including the GoT’s ongoing reforms of PHC with service provision systems and facilities.

Conclusion 4: The joint efforts of MoHSP, UNFPA and USAID was the best example of partnership that brought evidence to policy makers to establish a dedicated budget line for procurement of contraceptives. It should become the most recent and resourceful guide that should play as a key instrument in all advocacy and resource mobilization affords. This intervention has already proved its effectiveness in development of the State Programme on RH for 2019-2022, build contraceptive security roadmap and attract donors to support the Government transition toward self-financing covering financial gaps in procurement of contraceptives within the Joint Project on Strengthening National FP Services for 2017-2020.

Origin: EQ6-EQ7

UNFPA has already taken important steps toward ensuring FP issues addressed at the newly developed National Health Strategy 2020-2030. Since there are quite limited number of National and International agencies working on FP, cooperation with existing or new National and International partners including development and finance institutions to be strengthened through inter-sectoral work on advocacy, communications and awareness raising interventions and media relations to reach the those left behind. The State Programme on RH for 2019-2022 may become a strong platform under the leadership of MoHSP for collaboration with different agencies including civil society and public organizations and attract more donors for resource mobilization affords to address financial gap in procurement of a broad range of contraceptives, positioning FP beyond the health sector; and identifying effective demand interventions to end unmet need.

Maternal health

Conclusion 5: UNFPA contribution is aligned with the human rights-based approach on elimination of preventable maternal mortality and morbidity according to Human Rights Council resolution 18/2 (2011) that is underpinned by the principles of accountability, participation, transparency, empowerment, sustainability, non-discrimination and cooperation.

⁵⁰ UN A/69/62 (2014). Framework of Actions for the follow-up to the Programme of Action of the International Conference on Population and Development Beyond 2014. Report of the Secretary-General.

Worthy of note that according to official statistics and UN estimates, the maternal mortality has positive trends and declined by 68% during 2000 and 2017⁵¹. UNFPA long term and systematic approach to reorganization of MCH services according to effective perinatal care technologies and Beyond the Number programme, introduction of national standards and clinical protocols in maternity clinics were instrumental in terms of reducing preventable maternal and neonatal mortality and morbidity.

Comprehensive approach to strengthening of the MCH system resulted in quality of services: a) facility-based delivery and skilled birth attendance increased, b) earlier and post-delivery bleedings decreased, c) uterus rupture and hysterectomies, hemorrhagic shock and suppurative septic complications reduced, d) childbirth trauma decreased. Rights and choice based approach improved psychological condition of women pre/and postnatal periods. Considering cost effectiveness, efficiency and relevance of EPC and BTN programmes and standards to country context, it needs to be expanded in rural and district maternity clinics for addressing remaining challenges towards achieving UNFPA transformative goals on ending all preventable maternal deaths.

CO have undertaken a series of sequential actions on promotion of midwifery programme in line with International requirement. However, the role of midwives is still limited in provision of SRH, MH, FP and CCP services and regulation framework need to be strengthened as a further step. The National Association of midwives lack the leadership skills and need to be supported.

The MoHSP initiative on introducing district health information system (DHIS-2) is an effective channel for synthesizing the different reports to be used in programming and planning. CO could use DHIS-2 for development of Women's Register on RH&R. Though, DHIS-2 produces different types of reports however, use of these data by senior health managers need to be strengthened for decision making.

Origin: EQ-1, EQ-3, EQ-4, EQ-6, EQ-7, EQ-9

Conclusion 6: Pilot project on cervical cancer prevention provided strong evidence on its effectiveness and efficiency towards ending preventable death among women and this model project is applicable to for expansion in other regions.

The CP demonstrated effectiveness and efficiency of pilot cervical cancer screening programme in the country context, which made achievements beyond the initial project objectives. Capacity building activities contributed to improvement of overall SRH services that meet internationally agreed evidence-based standards and saved the lives of women from these preventable diseases and death.

Considering the alarming situation with cervical cancer in Tajikistan (high-level death among women of reproductive age - 400 cases annually as per WHO/assessment reports), it is recommended to expand this programme in other regions as well. However, given resources of donors and national partners are insufficient to address this burden and immediate actions are needed from both sides.

Origin: EQ-1, EQ-2, EQ-3, EQ-4, EQ-6, EQ-7

HIV Prevention

Conclusion 7: UNFPA has rightly focused on the health and well-being of key population. It is one of very few organizations to speak up and provide support for harassed and hushed up sex workers (SWs) and men who have sex with men (MSM) in the country.

UNFPA work in the area of HIV prevention among young people and among female sex workers (SWs) and men who have sex with men (MSM) is considered effective. UNFPA increased level of knowledge of those who are able to identify ways to prevent and reject misconception about HIV transmission among key pop. Very important role played outreach work of NGOs that was very vital in accessing communities directly. UNFPA supported community empowerment activities via NGOs. SW and MSM continue to face stigma and discrimination that make it difficult to reach them. MSM as a component was not included

⁵¹ Trends in Maternal mortality for 200-2017, UN Estimate

into the HIV National Programme 2017-2020, thus putting them further behind from the SRH services. During the evaluation it was revealed that STI knowledge among key pop is very low, especially among young key pop. Thus, evaluation team concludes that UNFPA should continue to support efforts to prevent HIV/STI among key pop, but with consideration of environment to do that. STI knowledge management by health professionals should be supported also. Established platform of HIV/SRH/STI integration can be used for this purpose. Further integration required into health sector with focus on primary health care level. From a human rights and public health point of view, it should expand its interventions to include efforts to reduce stigma and discrimination against SWs and MSM.

PwD represent another group of population, that require HIV prevention services and access to SRH services. Very limited data is available on their needs. Integration platform should also put some focus on this group.

Origin: EQ 1; EQ 2; EQ 3; EQ 4; EQ 6; EQ 7; EQ 8;

Adolescents

Conclusion 8: UNFPA has successfully promoted an increased priority on young people in national development policies, as such providing a further platform for institutionalization of the HLS into the education sector of the country;

Youth component of the country programme considered to be an effective. It has contributed to put ASRH on the national development agenda, especially in the health and education sectors. UNFPA has successfully promoted an increased priority on young people in national development policies. UNFPA has sensitized decision makers in education sector to include HLS into the National Strategy on Education 2030. Commitments on institutionalization of HLS at all educational level were obtained and presented at Nairobi. Therefore, high level commitment is available to push forward the HLS institutionalization in the country.

Due to relatively high level of HIV/STI cases among young people 15-24, introduction of HLS into secondary system considered as “push factor” with great potential for improving the situation.

As a complementary measure, and to meet the needs of young people outside the formal education system, and especially young women, peer education remains a pertinent complementary measure.

The suggested future youth programmatic component should be designed not only in consultation with institutional key partners, but also with the active involvement of young people themselves. Its efforts should go beyond the health care system and into other relevant sectors/platforms whose contributions can improve SRH and reproductive rights of young people.

Origin: EQ 1; EQ 2; EQ 3; EQ 4; EQ 6; EQ 7; EQ 8;

Gender

Conclusion 9: UNFPA support was instrumental in establishing multi-sectoral cooperation and response to GBV through introducing UN Global Essential Service Package and Standard Operating Procedures for health, police and psychosocial services that is strengthened the referral system.

UNFPA support was instrumental in establishing multisectoral cooperation and response to GBV and sustainable operation of GBV victim support rooms. Introduction of UN Global Essential Service Package and Standard Operating Procedures for health, police and psychosocial services made considerable inputs to improving services to victims of violence. The MoHSP adopted SOP for health sector and this needs to be rolled out by other sectors (police and social). All together contributed to strengthening of the referral and response system within different sectors. CO has to focus on institutionalization of multi-sectoral cooperation and response system. Most policy and strategy documents (Laws, strategies) including the National action plan CEDAW are operational mainly in the capital and regional centers and they need to be localized at district and rural levels for better results and changes.

There is a lack of single registration and reporting system of GBV cases in Tajikistan. Key involved state sectors register the cases within their institute and duplicate each other. Thus, there is lack reliable data on the number of GBV/SGBV cases.

Origin: EQ-1, EQ-3, EQ-4, EQ-6, EQ-7

Conclusion 10: CP introduced innovative approaches focusing on community of educated clients and bringing quality social and legal services close to remote rural areas reaching those who left behind.

Innovative programmes on demand creation and bringing services close to remote areas (Public health fairs) increased public awareness and access of rural population to health and legal services and importantly addressed the needs of those who left behind (migrants' wives, disable women and girls etc). This is an effective approach in addressing bottlenecks and supporting the principles of "reaching the furthest first and no one left behind" and need to be systematized involving donors and national partners.

Persistence of discriminatory attitudes, stereotypes and social norms in the country that normalize and permit violence is another obstacle in timely and efficient response to GBV. Therefore, mass media and awareness raising activities are important in addressing these challenges, promoting women and girl's right, to prevent early marriages and pregnancy, increasing their access to education and health etc. However, this is missed opportunity both for government sector and development partners in the country.

Origin: EQ-1, EQ-2, EQ-3

Population and development

Conclusion 11: UNFPA provided support to Agency on Statistics in the past was crucial and further capacity building, policy dialogue and knowledge management initiatives are important for successful conduction of the PHC. The further priorities and UNFPA value added will be an effort to make available nationwide and reliable socio-demographic data and their use for development of strategies and policy programmes/documents, investment programme, as well as sectoral planning and budgeting.

UNFPA as a leading agency in helping countries identify and understand trends in population dynamics and is one of the world's largest population data collection agency and provide technical support to AS to conduct Population and Housing Census in 2020 in line with international standards and requirements support and this support is crucial for successful implementation of the 2020 PHC. In PHC preparatory phase UNFPA focused on building institutional capacity, planning and management, mapping employing Geographic Information System (GIS), questionnaire design and testing, field operations during the Pilot PHC in October 2018, publicity campaign, mobile data capture.

Origin: EQ-2, EQ-3 EQ-7

Conclusion 12: UNFPA contributed to all outputs and outcomes of the joint Civil Registration Reform Project by conducting several and consecutive activities including technical assistant, surveys and capacity building in cooperation with CSOs. To ensure ownership and sustainability of the program it is crucial to maintain effective partnership with the Government and UN Sister agencies.

UNFPA produced comprehensive assessment report which contains important recommendations on reforming CRVS law in order to meet the needs of AS and also to meet the UN requirements. As a next step MoJ was supported on developing a roadmap for implementation of recommendations on the legal and regulatory framework, statistical functionality, data flows and development of information mapping for civil registration system. UNFPA conducted CRVS data flow assessment between CRVS system stakeholders such as MoHSP, AS and other government agencies. The comprehensive assessment allows to identify system, procedural, resource, technological, and functionality gaps, and improvement plan presented to project stakeholders. UNFPA advocated to bring the CRVS reform issues into the agenda of

the National Commission on Population and Development, lower house of Parliament (Majlisi Namoyandagon) of the Republic of Tajikistan. The very low level of legal awareness among rural population, which considered as one of the main obstacles in provision of CRVS services, it was planned to launch information campaigns to address this issue. Hence, UNFPA also contributed to population behavior changes through organizing nationwide information campaign and mobile consultations on importance and timely registration of vital events and found that changes in behavior of CRVS staff is crucial to achieve the overall Project goal. To improve the situation with timely registration of the vital events advancements should be from supply (MoJ) and demand (population) sides. Therefore, the sets of planned activities were directed to build the capacity of MoJ and civil registration offices staff from one hand and raising awareness campaign by selected CSOs complement to the Ministry of Justice communication strategies, on the other hand. Moreover, qualitative survey was conducted with aim to identify isolated communities in target districts (B. Gafurov, J. Balkhi and Rudaki) without vital event registration, reasons are defined and were provided relevant policy recommendations.

Origin: EQ-2, EQ-3 EQ-7

Emergency response preparedness

Conclusion 13: UNFPA has made huge efforts to establish the official Thematic SRH Working Group under the MoHSP and introduce multi-sectoral GBV prevention platform which are operational and practically effective. Support provided by UNFPA in development and integrating National and Regional Action Plans on SRH in emergencies, training over 200 SRH specialists on Minimum Initial Service Package for SRH in crisis including Adolescents SRH and GBV prevention, building and integrating SOPs and Clinical protocol on provision of medical services to the victims of violence was quite crucial and appreciated.

Origin: EQ2-EQ3

Although coordination of different interventions on SRH and GBV through multi-sectoral mechanisms or thematic platforms were seen quite effective, there is still a gap in application of laws, policies and strategies as well as guidelines designed to be performed in normal days without aligning to possible emergency scenarios that could affect the overall performance of such interventions. UNFPA will take a stronger role in advocating different platforms to consider emergency scenarios to ensure that SRH and GBV services are available at on the onset of any emergency. In addition, UNFPA will need to strengthen multi-sectoral work under specific clusters to ensure that funding of both state and humanitarian agencies is available to run operational activities throughout the year. This will ensure that coordination platforms in both normal days and emergencies are functional to perform full set of duties and responsibilities.

CHAPTER 6: Recommendations

5.1: Strategic level

Recommendation 1: UNFPA should further strengthen integrated approach for results-based management to enhance programme effectiveness by participatory approach engaging national partners and beneficiaries to programme design, implementation and monitoring, ensuring organizational consistency to country context, focusing on efficiency and continuity, advocating for mutual accountability and transparency.

Priority: High

Target level: UNFPA CO

Based on conclusion #1

Operational implications:

1. The next UNFPA Country Programme should build on lessons learned, preserve gains and sustain progress made over the current CP focusing on national priorities and international commitments and considering political, social and economic trends. National priorities and international commitments should be well balanced in the new CP.
2. The UNFPA should conduct extensive needs assessment and situational analysis, explore more evidences on missed opportunities, and initiate consultation with the key partners.
3. Ensure national ownership and participatory approach through engaging youth and beneficiaries (women, girls, migrants' wives, disable people, PLWH, young mothers) for the next programme design, implementation and monitoring.
4. The new CP should be in line with UNDAF priorities, the National Midterm Development Programme 2021-2025, NDS and other new sectoral strategies (health, education).
5. CO should focus on reducing regional inequality and address the needs and priorities of the most vulnerable population (women and girls with disabilities, migrants' wives). This will require careful prioritization of supported interventions and keep integrated approach for reaching furthers behind. CO should conduct needs assessment of the most vulnerable population systematically, identify gaps and address them accordingly.
6. CO need systematically analyze financial and human resources and make adjustments, where necessary.

Recommendation 2: UNFPA should strengthen UNFPA CO Coordination, Advocacy and Strategic Partnerships and develop CO Communication and Advocacy (CA) Strategy based on UNFPA CA Strategy in the context of Nairobi commitments and country context. CO should consider partnership with traditional and non-traditional partners including private sectors.

Priority: High

Target level: UNFPA CO

Based on conclusion #2

Operational implications:

1. Develop CO Communication and Advocacy Strategy and Action Plan in line with national priorities and international commitments and maintain systematic approach. Develop partnership with mass media and build capacity of journalist on UNFPA mandate.
2. Support One UN approach and joint programming/planning.
3. Maintain leadership in assisting the government partners with policy and strategy development in line with international standards. Continued advocacy and police advise in frame of national commitments made in Nairobi towards achieving unfinished business on ICPD PoA and SDGs. Objectively pursue political trends and support partnerships and the functioning of the National

- population and development Committee as an important political board for achieving national commitments.
4. Continue focus on strategic partnership and mobilization of resources. Alternative innovative partnership with traditional and non-traditional partners including private sector will bring new opportunities in promoting ICPD and SDG.
 5. Tajikistan is re-classified to “low income country” and this need to be considered within new CPD development.

6.2: Programmatic level

Family planning

Recommendation 3: Ensure a focused rights-based approach on FP and expand the range of modern contraceptive methods to maximize the efficiency of FP programme, and to position FP as an integral part of UHC.

Priority: High

Target level: UNFPA CO

Based on conclusion #3

Operational implications:

1. CO shall request UNFPA HQ to reconsider Tajikistan eligibility for contraceptives support in view of reduced income status of the country and to support further contraceptive security roadmap toward state-funded National FP Programme.
2. Researches or in-depth studies on client satisfaction with family planning services in the area of high unmet need should be considered taking into account a huge unknown gap between high knowledge on FP methods and low uptake in different age groups.
3. Integrate FP services as part of essential RMNCAH packages and STI/HIV services; integrate FP into non-health programmes such as on GBV, harmful practices and gender equality.

Recommendation 4: Use available mechanisms for sustainability of FP interventions by developing and integrating an exit strategy such as the State Programme on RH.

Priority: High

Target level: UNFPA CO

Based on conclusion #4

Operational implications:

1. UNFPA should strive to support State Programme on RH for the period of 2019-2022 which promotes strengthening quality education on family planning, increased accessibility, quality and efficacy of family planning services for population, primarily focusing on youth.
2. UNFPA should further bring strong and evidence-based practices on post-partum family planning as a golden "missed" opportunity to ensure that women in post-partum period do receive quality information and contraceptive assistance including long term and permanent methods such as IUD and voluntary surgical sterilization within the first three days at maternity. This will avoid unnecessary testing on HIV and Hepatitis since women at pregnancy do already take them.
4. Although the Government is still facing with challenges in integration of FP services at PHC under the family medicine model, UNFPA should further advocate on ensuring that OBGYNs and midwives are included in the team of PHC facility and their roles are clearly defined and strengthened;
5. UNFPA should further support development of distance learning platforms on SRH/FP at higher and mid-level medical education facilities, including pre and post-diploma continuous education facilities. This will ensure that internationally recognized educational packages are integrated into the school curricula and graduates are well-prepared to immediately render their services upon graduation.

Maternal health

Recommendation 5:

The UNFPA-supported evidence based programmes are essential for making a lifesaving and long-lasting impact on women's and child's health and eliminating preventable maternal and newborn morbidity and mortality. The next CP should continue human rights based and integrated approaches in mother and child health with particular attention to district and rural areas based on quality data.

Priority: High

Target level: UNFPA CO

Based on conclusion #5

Operational implications:

1. CO will advocate for and support use of near miss cases review in all 2nd and 3rd level maternity clinics to reduce preventable maternal death. CO should support the Republican Association of Obstetrician and Gynecologists and build capacity for managing maternal death Audit.
2. In partnership with development partners CO should promote Midwifery programme and support the National Association of Midwives for their leadership in increasing the role of midwives in integrated SRH services.
3. CO should support the MoHSP with implementation of EPC programme and national standards in district and rural maternity clinics.
4. CO should continue supporting improving quality of data collection, reporting, analysis and use for decision-making in SRH/MH through involvement to DHIS-2.

Recommendation 6:

UNFPA should continue efforts on expansion of cervical cancer prevention programme in Tajikistan in the frame of elimination of preventable death and diseases among women

Priority: High

Target level: UNFPA CO

Based on conclusion #6

Operational implications:

1. Taking into account alarming situation with CC and high level of death among women of reproductive age and based on experience of successful implementation of model CCP in Tajikistan, it is recommended to consider expanding this experience in other regions.
2. UNFPA should continue advocacy work with national and developments partners to assist the MoHSP with development of national action plan on CCP determining short, mid and long term objectives. Create partnership with traditional and non-traditional partners and mobilize additional resources for the quality screening and treatment programmes, including institutionalization of effective quality assurance mechanisms. Promote development of unified cancer registry to achieve successful implementation of this innovative programme for Tajikistan.

HIV

Recommendation 7:

Considering the fact, that HIV is on the rise in the country, it is recommended to continue to work with SW and MSM including on STI prevention and knowledge management.

Priority: High

Target level: UNFPA CO

Based on conclusion #7

Operational implications:

1. Continue comprehensive HIV/STI prevention among SW and MSM, including work among PwD.
2. To support networking initiatives to address discrimination and human rights, including of SWs, MSM and PwD.

Adolescents**Recommendation 8:**

Education sector of the country is mandated to equip children and young people with the knowledge, skills and attitudes they need to live safe and healthy lives. Since importance of comprehensive sexual and reproductive health education has been recognized as an integral component of the healthy lifestyle education programmes, it is necessary to promote further institutionalization of the HLS.

Priority: High

Target level: UNFPA CO

Based on conclusion #8

Operational implications:

1. Continue efforts on institutionalization of HLS into the educational system.
2. Increase coordination between MoE and other relevant state institutions, i.e. MoH, on HLS institutionalization.

Gender equality**Recommendation 9:**

UNFPA should continue efforts on institutionalization the multi-sectoral cooperation response to GBV/SGBV against women and girls with particular focus on leaving no one behind in the context of SDG principles

Priority: High

Target level: UNFPA CO

Based on conclusion #9, 10

Operational implications:

1. UNFPA should continue efforts on implementing innovative approaches on increasing access of victims of GBV/SGBV to quality services through the partnership and networking of Victim Support Rooms, Youth friendly services, CSOs, promoting Papa/Mama schools. The multi-sectoral cooperation response need to be strengthened and institutionalized. UN essential service package and SOPs (police, health, and psychosocial services) need to be nationalized and integrated into educational programmes.
2. CPE recommend CO to assist national partners with strengthening GBV registration system in the country.
3. UNFPA should continue efforts for monitoring and implementation of human rights treaties. Ensure institutionalization of behavior change communication strategies and promote demand creation and awareness raising on addressing GBV, stereotypes and discrimination against women and girls, promote innovative approaches on brining services to remote areas and reaching furthest behind.
4. In the context of SDG principles “leaving no one behind”, it is recommended supporting activities on ensuring the rights and needs of women and girls’ with disabilities and their access to GBV and SRHR services.

Population and development

Recommendation 10:

Coherent, reliable and internationally comparable statistics are important for the monitoring of social and economic progress of a country and UNFPA by supporting of 2020 PHC will contribute on availability nationwide age-sex and spatial disaggregated socio-economic and demographic data to monitor country's development agenda, and monitoring of SDGs and NDS indicators.

Priority: High

Target level: UNFPA CO

Based on conclusion #11-12

Operational implications:

It is highly recommended further to continue capacity building initiatives of national partners on PHC publicity campaign, data collection and processing, data analysis and evaluation, thematic publication and data dissemination employing new data collection, analysis and mapping software, thus, to contribute on: (i) development of national and sub-national planning, programming, and budgeting; (ii) producing national and sub-national population projections for planning public investments; (iii) mapping population characteristics by socio-economic and demographic characteristics; and (iv) defining needs and address inequalities of those are furthest behind.

Emergency response preparedness

Recommendation 11: Strengthen UNFPA humanitarian priorities at the national preparedness and response plans in accord with the framework of UNSDCF and UHC linking with the Sustainable Development Agenda and targets and priorities set by the Sendai Framework for DRR 2015-2030.

Priority: Medium

Target level: UNFPA CO

Based on conclusion #13

Operational implications:

1. UNFPA should further advocate for sustained, multiyear and flexible financing of national platforms focused on preparedness and transition phases, and promote domestic funding and other bridging mechanisms are available to ensure SRHR services are available;
2. UNFPA should further advocate aligning thematic coordination platforms working on cross-cutting issues such as GBV, HIV and SRH including young people needs and availability of data despite the absence of humanitarian profiles that the member agencies may or may not have. This will ensure that laws, policies, strategies, guidelines developed to be provided in normal days are fully applicable and available in times of emergencies.
3. UNFPA should further reinforce quality of care as the foundation for an integrated SRHR package of services that meets the needs of affected populations including vulnerable groups;

Annexes

Annex 1: Terms of Reference

TERMS OF REFERENCE FOR INDIVIDUAL CONSULTANT FOR THE EVALUATION OF THE TAJIKISTAN UNFPA COUNTRY PROGRAMME (2016-2020)

TERMS OF REFERENCE (to be completed by Hiring Office)	
Hiring Office:	UNFPA Country Office in Tajikistan
Purpose of consultancy:	<p>The overall objectives of evaluation: (i) an enhanced accountability of UNFPA and its country office for the relevance and performance of its country programme and (ii) a broadened evidence-base for the design of the next programming cycle.</p> <p>The specific objectives:</p> <ul style="list-style-type: none"> To provide an independent assessment of the progress of the country programme towards the expected outputs and outcomes set forth in the results framework of the respective country programme; To provide an assessment of country office (CO) positioning within the developing community and national partners, in view of its ability to respond to national priority needs while adding value to the country development results. To draw key lessons from the past and current cooperation and provide a set of clear, specific and action-oriented forward-looking strategic recommendations in light of agenda 2030 for the next programming cycle. <p>The evaluation is expected to be completed by October 2019 and carried out in accordance with the Evaluation Implementation Plan.</p> <p>Scope of evaluation:</p> <p>The evaluation will cover Tajikistan and the following four programmatic areas: Reproductive Health, Adolescents and Youth, Gender Equality and Population and Development. During the evaluation there may be field visits to relevant areas and several interviews with key stakeholders.</p> <p>The evaluation will cover all activities planned and/or implemented during the period 2016-2018. Cross-cutting areas will include: partnership, resource mobilization and communication.</p> <p>The 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.</p>
Scope of work: (Description of services, activities, or outputs)	<p>EVALUATION PROCESS</p> <p>The evaluation will unfold in four phases, each of them including several steps.</p> <p>a. Evaluation design phase (4 weeks in 2nd week of June – 2nd week of July) This phase will include:</p> <ul style="list-style-type: none"> a documentary review of all relevant documents available at UNFPA HQ and CO levels regarding the country programmes for the period being examined; a stakeholder mapping – The evaluation manager will prepare a mapping of stakeholders relevant to the evaluation. The mapping exercise will include state 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; the development of a data collection and analysis strategy as well as a concrete work plan for the field phase. <p>At the end of the design phase, the evaluation team leader will produce a design report, that will outline the detailed evaluation methodology, criteria, timeframes and the structure of the final report.</p> <p>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.</p> <p>b. Field phase (First-second week of August 2019)</p> <p>After the design phase, the evaluation team will undertake a three-week collection and analysis of the data required in order to answer the evaluation questions final list consolidated at the design phase. At the end of the field phase, the country evaluation team will provide the COs with a debriefing presentation on the preliminary results of the evaluation, with a view to validating preliminary findings and testing tentative conclusions and/or recommendations.</p> <p>c. Synthesis and dissemination phase (10 weeks in fourth week of - August – fourth week of October)</p> <p>During this phase, the Country Evaluation Team will continue the analytical work initiated during the field phase, taking into account comments made by the Evaluation Steering Committee and Evaluation Reference Group at the debriefing meeting and the Evaluation Team Leader.</p> <p>This first draft country report will be submitted to the Evaluation Reference Group for comments (in writing). Comments from the Country Evaluation Reference Group and evaluation managers will be consolidated. The draft country report will form the basis for a dissemination seminar/s, which will be attended by the CO as well as all the key</p>

	<p>programme stakeholders in the Evaluation Reference Group (including key national counterparts). The final report will be drafted by the Team Leader based on the comments received. This first draft evaluation report will be shared with the Evaluation Steering Committee for the feedback and comments. The final Evaluation report will be shared with stakeholders in the country, in a format to be agreed upon.</p>																																													
<p>Duration and working schedule:</p>	<p>Remuneration and duration of contract</p> <p>The provisional allocation of workdays among the evaluation team will be the following:</p> <table border="1" data-bbox="414 313 1532 694"> <thead> <tr> <th>Evaluation Phase</th> <th>Team Leader International Consultant</th> <th>Evaluator 1</th> <th>Evaluator 2</th> <th>Evaluator 3</th> </tr> </thead> <tbody> <tr> <td>Preparation (scoping mission)</td> <td>5</td> <td>10</td> <td>5</td> <td>5</td> </tr> <tr> <td>Design</td> <td>10</td> <td>20</td> <td>15</td> <td>10</td> </tr> <tr> <td>Fieldworks</td> <td>10</td> <td>15</td> <td>15</td> <td>15</td> </tr> <tr> <td colspan="5" style="text-align: center;">Reporting, including:</td> </tr> <tr> <td><i>Contribution to first draft report</i></td> <td>5</td> <td>10</td> <td>5</td> <td>5</td> </tr> <tr> <td><i>Consolidation and finalization of the final report</i></td> <td>3</td> <td>8</td> <td>3</td> <td>3</td> </tr> <tr> <td><i>Preparation and facilitation of stakeholder workshop</i></td> <td>2</td> <td>7</td> <td>2</td> <td>2</td> </tr> <tr> <td>Total</td> <td>35</td> <td>70</td> <td>45</td> <td>40</td> </tr> </tbody> </table> <p>Notes:</p> <p>Evaluator 1 – Sexual and Reproductive Health Component (Maternal Health, Family Planning and HIV);</p> <p>Evaluator 2 – Youth and Gender;</p> <p>Evaluator 3 – Population and Development</p> <p>Payment of the evaluation consultancy fee for National Evaluators will be made in two tranches against the following milestones:</p> <ul style="list-style-type: none"> ● 40% Upon acceptance of the first draft final evaluation report by UNFPA ● 60% Upon acceptance of the final evaluation report by UNFPA <p>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.</p>	Evaluation Phase	Team Leader International Consultant	Evaluator 1	Evaluator 2	Evaluator 3	Preparation (scoping mission)	5	10	5	5	Design	10	20	15	10	Fieldworks	10	15	15	15	Reporting, including:					<i>Contribution to first draft report</i>	5	10	5	5	<i>Consolidation and finalization of the final report</i>	3	8	3	3	<i>Preparation and facilitation of stakeholder workshop</i>	2	7	2	2	Total	35	70	45	40
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<p>Place where services are to be delivered:</p>	<p>Dushanbe, Tajikistan with site visit to the regions across the country.</p>																																													
<p>Delivery dates and how work will be delivered (e.g. electronic, hard copy etc.):</p>	<p>I. EVALUATION CRITERIA AND EVALUATION QUESTIONS</p> <p>The following evaluation questions addressing the evaluation criteria: relevance, effectiveness, efficiency, and sustainability as well as coordination with the UNCT, and added value will be used for the evaluation.</p> <p><i>Relevance:</i></p> <ul style="list-style-type: none"> ● EQ1. To what extent is the UNFPA support (i) adapted to the needs of the population with emphasis to the most vulnerable population (ii) in line with the priorities set by ICPD Plan of Action and national policy frameworks related to UNFPA mandated areas, (iii) aligned with the UNFPA strategic plan in particular Strategic plan principles (leaving no one behind and reaching the furthest behind), transformative goals, and business model and (iv) aligned with the UN Partnership Framework? <p><i>Effectiveness:</i></p> <ul style="list-style-type: none"> ● EQ2. To what extent have the intended programme outputs been achieved? ● EQ3. 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 gender equality, and iv. developing of evidence-based national population policies) and what was the degree of achievement of the outcomes? ● EQ4. To what extent has UNFPA policy advocacy and capacity building support helped to ensure that sexual and reproductive health (including Family Planning), and the associated concerns for the needs of young people, gender equality, and relevant population dynamics are appropriately integrated into national development instruments and sector policy frameworks in the programme country? <p><i>Efficiency:</i></p> <ul style="list-style-type: none"> ● EQ5. 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 country programme? <p><i>Sustainability:</i></p> <ul style="list-style-type: none"> ● EQ6. To what extent have the partnerships established with ministries, agencies and other representatives of the partner government allowed the country office to make use of the comparative strengths of UNFPA, while, at the same time, safeguarding and promoting the national ownership of supported interventions, programmes and policies? ● EQ7. To what extent have partnerships built with government or other UN organizations to enhance sustainability or scale up interventions and/or bring relevant evidence to policy-makers to adopt such approaches? 																																													

UNFPA Country programme coordination with UNCT:

- EQ8.To what extent has the UNFPA country office contributed to the functioning and consolidation of UNCT coordination mechanisms?

UNFPA Country programme added value:

- EQ9.What is the main UNFPA added value in the country context as perceived by UNCT and national stakeholders?

II. METHODOLOGY AND APPROACH

The evaluation will be based on a participatory design that is expected to include quantitative and qualitative data collection methods.

The proposed methodology by the evaluation team will elaborate in detail on the relevant data sources, sampling size and techniques, data collection instruments and procedures, ethical considerations, as well as the strategies necessary for mitigating the major limitations of the proposed design, if any.

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 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**.

Data validation

The Evaluation Team will use a variety of methods to ensure the validity of the data collected. Besides a systematic triangulation of data sources and data collection methods and tools, the validation of data will be sought through regular exchanges with the CO programme managers and the Evaluation Reference Group.

Data Analysis

The evaluation team will ensure the following in analyzing data, formulating finding and reaching to conclusions.

- Are the findings substantiated by evidence?
- Is the basis for interpretations carefully described?
- Is the analysis presented against the evaluation questions?
- Is the analysis transparent about the sources and quality of data?
- Are cause and effect links between an intervention and its end results explained and any unintended outcomes highlighted?
- Does the analysis show different outcomes for different target groups, as relevant?
- Is the analysis presented against contextual factors?
- Does the analysis elaborate on **cross-cutting issues such as equity and vulnerability, gender equality and human rights?**

Stakeholders participation

The evaluation will adopt an inclusive approach, involving a broad range of partners and stakeholders. **The evaluation manager will perform a stakeholders mapping** for the country 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. The stakeholder mapping must be concluded before the design phase.

An **Evaluation Reference Group (ERG)** will be established by the UNFPA Country Office comprising key programme stakeholders (national governmental and non-governmental counterparts, Evaluation Manager from the UNFPA Country Office). The ERG will review and provide inputs to the country 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 case studies at the draft stage.

IV. WORK PLAN/ INDICATIVE TIMEFRAME

Phases/deliverables	Dates
Evaluation design phase: - Submission of the design report	Mid-June - July 2019
Training phase: - Training on evaluation design	July 2019
Field phase: - Data Collection - Debriefing CO	Mid July - August 2019
Synthesis and dissemination phase: - 1st draft Evaluation Report - Dissemination - 2nd draft Evaluation Report - Final Evaluation Report	End -August – End -October

Monitoring and progress control,

EXPECTED OUTPUTS/ DELIVERABLES

<p>including reporting requirements, periodicity format and deadline:</p>	<p>The evaluation team will produce the following deliverables:</p> <ul style="list-style-type: none"> ● 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 30 pages; ● a first draft evaluation report 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 evaluation report (followed by a second draft, taking into account potential comments from the Evaluation Steering Committee) and Evaluation Reference Group. The evaluation report should have a maximum of 50 pages (plus annexes); a presentation of the results of the evaluation for the dissemination seminar to be held and led by the national evaluators; ● a final evaluation report, based on comments expressed during the dissemination seminars. ● An evaluation brief (maximum 4 pages) summarizing the evaluation report. <p>All deliverables will be written in English and Russian. The presentation for the dissemination seminars and the final evaluation report might need to be translated in Tajik if requested by national counterparts.</p> <p>For reporting requirements, periodicity format and deadline see section above.</p>
<p>Supervisory arrangements:</p>	<p>MANAGEMENT AND CONDUCT OF THE EVALUATION</p> <p>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 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 Country Office.</p> <p>The Evaluation Steering Group:</p> <p>Evaluation Steering Committee (ESC) will have overall responsibility for management and coordination of all components of the evaluation including evaluation design, implementation and dissemination of the evaluation results. The Evaluation Steering Committee will have overall supervision on the Evaluation Team (including International Team Leader and National Team) and evaluation processes. ESC will be comprised of the UNFPA Country Director, Assistant Representative, Programme staff and RO M&E Advisor.</p> <p>The role of the ESC will include the following tasks, but not limited to:</p> <ul style="list-style-type: none"> ● Develop and agree ToR for the evaluation along with ToR for Reference Group(s) and ToRs for all Evaluation Team members (International Team Leader and National Experts); ● 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 the 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. <p>The Evaluation Manager will:</p> <ul style="list-style-type: none"> ● Provide support to the whole evaluation exercise, provide feedback for quality assurance during the preparation of the design report, field work, case studies, dissemination seminar, and the final report; ● Conduct stakeholders mapping; ● Provide Evaluation team with available internal and external data relevant to the country ● Facilitate the establishment of the Reference Group ● Be supported by the RO M&E adviser <p>The reference group composed of representatives from the UNFPA country office, the national counterparts, the UNFPA regional office as well as from UNFPA relevant services in headquarters.</p> <p>The main functions of the Reference Group will be:</p> <ul style="list-style-type: none"> ● to discuss the terms of reference drawn up by the evaluation manager; ● to provide the evaluation team with relevant information and documentation on the programme; ● to facilitate the access of the evaluation team to key informants during the field phase;

	<ul style="list-style-type: none"> to discuss the reports produced by the evaluation team; to advise on the quality of the work done by the evaluation team; to assist in feedback of the findings, conclusions and recommendations from the evaluation into future programme design and implementation.
Expected travel:	<i>Mid July - August 2019</i>
Required expertise, qualifications and competencies, including language requirements:	<p>COMPOSITION OF THE EVALUATION TEAM</p> <p>An Evaluation Team Leader and three Evaluators who are external to UNFPA will carry out the evaluation. There should be at-least one member in the evaluation team should be female. The evaluation team members will combine knowledge and experience in evaluation with technical knowledge and expertise in areas related to the UNFPA development and humanitarian programme</p> <p>The evaluation team will consist of:</p> <p>a) International Evaluation Team Leader with overall responsibility for the design and implementation of the CPE. S/he is responsible for the production and timely submission of all expected deliverables of the CPE including design report, draft and final evaluation reports. She/he will lead and coordinate the work of the Evaluation Team and ensure quality of the evaluation products. The Evaluation Team Leader will be responsible for covering at least one programmatic area of the CPE.</p> <p>2) Three National Evaluators (Evaluation team members), who will each provide expertise in one programmatic area of the evaluation The evaluators 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 Evaluation Team Leader. The modality and participation of evaluators in the CPE 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.</p> <p>The necessary qualifications of the evaluators will include:</p> <ul style="list-style-type: none"> Advanced degree in social sciences, public health, women's studies, gender equality, population studies, demography, statistics or related fields; At least 5-7 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; Good knowledge of the national development context and be fluent in Tajik, Russian and English Familiarity with UNFPA or UN programming; Excellent writing and communication skills;
Inputs / services to be provided by UNFPA or implementing partner (e.g support services, office space, equipment), if applicable:	All relevant documents related to the evaluation process will be shared with evaluation team.
Other relevant information or special conditions, if any:	<p>INTRODUCTION</p> <p>The United Nations Population Fund (UNFPA) is the lead United Nations sexual and reproductive health agency for ensuring rights and choices for all. The strategic goal of UNFPA globally is to achieve three transformative results by 2030: ending unmet need for family planning, ending preventable maternal deaths, and ending gender-based violence and harmful practices. 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).</p> <p>UNFPA Country office in Tajikistan implements its 4th Country Programme for 2016-2020 and needs to carry out a Country Programme Evaluation (CPE).</p> <p>As the current programme cycle is approaching completion, the UNFPA Country Office in Tajikistan, in collaboration with the UNFPA Regional Office for Eastern Europe and Central Asia and UNFPA Evaluation Office, is planning to conduct an independent evaluation of the fourth UNFPA Country Programme for Tajikistan (2016-2020) as part of the Country Office evaluation plan and in accordance with the UNFPA evaluation policy (DP/FPA/2013/5). The CPE will provide an independent assessment of relevance, performance and sustainability of UNFPA support provided to Tajikistan during 2016-</p>

2018, as well as analysis of various facilitating and constraining factors influencing programme delivery.

Key features of this evaluation approach are: the evaluation focus will be on one country and the evaluation will cover relevance and effectiveness of the different strategies adopted in the country and thematic/programmatic areas. The overall objective of the evaluation is to assess the extent to which the country programmes achieved intended results and use the findings for the purposes of further programme design and interventions. The primary users of this evaluation are the decision-makers within the UNFPA country offices and organization as a whole, government counterparts in the country, the UNFPA Executive Board, 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 the country office evaluation manager 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 evaluation and prepare the evaluation report.

COUNTRY PROFILE

Since 2000, Tajikistan has experienced prominent economic growth. Despite the steady annual growth of the gross domestic product (GDP) almost in the last decade (7 per cent), Tajikistan remains one of the least developed countries in Eastern Europe and Central Asia (EECA) region (Agency on Statistics of Tajikistan [AS], Tajikistan in Figures, 2018). Lack of natural energy resources, the arduous transition to a market economy with aftermath of the regional economic crisis has put significant pressure on the population. The World Bank has classified the country as a low-income country. Nevertheless, wide disparities remain in access to services – by rural-urban status, region, wealth quintile and gender – along with other important social dimensions, such as disability, opportunities for youth and vulnerability to man-made and natural disasters, as well ongoing process of climate change.

The last Population and Housing Census was conducted in 2010 and the upcoming is planned in 2020. According to the Agency on Statistics under the President of the Republic of Tajikistan the total population of Tajikistan is 9.2 million people, over ¾ which lives in rural areas. The annual rate of population growth rate during the last 25 years around 2.1 percent. The median age of country's population in 2018 was 22.8 years. Slightly more than half (50.1 percent) are female population (AS, 2019).

Sexual and Reproductive Health (SRH)

UNFPA mainly focused on advocacy for and provide technical assistance in revising the existing, and developing new, national policies and plans that prioritize universal access to sexual and reproductive health, enhance the capacity of national institutions in strengthening the skills of health service providers to deliver stigma-free, client-oriented sexual and reproductive health services, including maternal health, family planning and cervical cancer prevention, enhance the capacity of national institutions to provide client-tailored, integrated sexual and reproductive health services for youth and key populations, facilitate implementation of the total marketing approach for contraceptives and advocate for increased domestic funding for procurement of family planning commodities, and further strengthen the contraceptive logistics and management system to ensure sustainable commodity security at the facility level.

Maternal health

The Ministry of health and social protection of Tajikistan has approved an Action Plan on sexual and reproductive health of mothers, new-borns, children and adolescents for the period 2016-2020 in the frame of the National Health Strategy of the Republic of Tajikistan. Mother and child health system is reorganized according to effective perinatal care programme. Rural maternity wards provide basic emergency obstetric care (EmOC) and district and city maternities are providing comprehensive EmOC

services according to national standards based on evidence-based strategies. Referral system of pregnant women to the second and third levels is in place. Primary health care is reorienting its services mostly focusing on preventable services rather than treatment which are cost effective. Family practitioners are providing multi-profile services regardless of gender and age according to international standards.

In the frame of a global initiative to reduce preventable diseases and deaths among women, the country office supports the Ministry of Health and Social Protection (MoHSP) in implementing the Cervical Cancer Prevention Programme for early detection and treatment of precancerous cervical diseases.

A 2017 Tajikistan Demographic and Health Survey (DHS 2017) data indicates an improvement in the mother and child health. The maternal mortality ratio (SDG indicator 3.1.1.) is significantly declining according to both official data and independent estimates (official statistics: 2015 - 28.4 and 2017 – 24.1; UN estimates: 2013 - 44 and 2015 – 32 per 100 000 live birth).

Now, in Tajikistan more children are surviving early childhood than ever before. The Under 5 Mortality Rate (U5MR) declined from 43 per 1,000 live births in 2012 to 33 in 2017 (DHS 2017) and Infant Mortality Rate (IMR) from 34 per 1,000 live births in 2012 to 27 in 2017 (DHS 2017).

Proportion of births attended by skilled health personnel (SDG Indicator 3.1.2) has a positive tendency which increased from 87% in 2012 to 95% in 2017.

Family planning

The Government of Tajikistan has identified Family Planning/Reproductive health commodity security as a priority first mean to realize the right of being informed and having access to safe, effective, acceptable methods for family planning for men and women as described in the Reproductive Health and Rights Law of 2002 (revision 2015). It is also an important development tool to reduce maternal mortality, improve the health of women, their children, families and communities reaffirmed by the National Comprehensive Health Strategy 2010-2020.

Particularly, affords of Tajikistan were made in integration of SRH/FP services provided by 90 Reproductive Health Centers across the country with Family Medicine provided at PHC level (app 1800 facilities) Support was provided in revision of functions and responsibilities of Family Medicine doctors and nurses and their capacity to provide quality FP services. Further development of standards, protocols and guidelines in FP service provision, development of job aids, expansion of contraceptive supply management and awareness raising on FP among population were defined as key activities within the current CPD. Considerable focus was made on high level advocacy affords to ensure the Government initiates funding allocations to sustain National FP Services.

It worth mentioning that in 2016, MoHSP created a budget category for the procurement of RH commodities that includes contraceptives. Procurement of contraceptives using the state budget was done in 2016 for the first time at US\$ 10,000. This allowed the Government of Tajikistan to initiate development of the National Implementation Plan for Family Planning and mobilize additional resources within the Joint Project on Strengthening National FP Services for the period of 2016-2020 at 2.7 million US\$ jointly funded by the Government of Japan, Government of Tajikistan and UNFPA. Currently the contribution of the government of Tajikistan has raised by US\$ 50,000 in 2019 with further commitment to reach US\$ 115.000 by 2020. This should be considered as a political commitment of the Government of Tajikistan into the FP programme within the international agreements and global strategies as SDGs, FP 2020 and Global Strategy on Women, Children and Adolescent's Health till 2030.

Based on MoHSP official medical statistics the Contraceptive Prevalence Rate (CPR) has increased from 30.0% in 2016 by 40.1% in 2018 for all methods of FP. Although the official statistics varies from that provided by 2017 DHS (29% in 2017), the use of modern methods of contraceptives is increasing but slowly. The level of induced abortions dropped down from 64.8 to 55.3 per 1000 women.

Availability of at least 3 types of contraceptives have raised from 65% (1170 facilities) in 2016 by almost 80% (1440 facilities) in 2018 at PHC facilities across the country.

In addition, UNFPA's involvement in humanitarian context has increased ever since the needs of women, girls, most vulnerable became obviously neglected through manifold situation reports, preventable maternal deaths, and increasing number of GBV cases across the world. The 2017-2021 UNFPA Strategic Plan as well as the UNFPA's Second Generation Humanitarian Strategy put stronger measures to ensure that reproductive health, gender and data issues are addressed in the National Humanitarian Preparedness Strategies and Action Plans.

In this regard, UNFPA affords first were made at high level advocacy among both Government and UN coordination mechanisms such as the Rapid Emergency Assistance and Coordination Team. With UNFPA advocacy national health services include SRH and GBV prevention measures in times of crisis.

Thematic SRH Working Group established under the MoHSP. This group developed and approved the National Action Plan on SRH and 3 Regional Action Plans on SRH in Emergency Situations that incorporate the objectives of the Minimum Initial Service Package (MISP) for SRH in Crisis and GBV prevention measures within the Guidelines on integration GBV interventions in humanitarian settings. MISP training package is adopted and provided by the National team of trainers of the MoHSP. SRH team adopted the Standard Operating Procedures on provision of medical services to the victims of GBV during crisis along with the Clinical Protocol approved by MoHSP.

With UNFPA advocacy SRH and GBV prevention interventions incorporated in the National Disaster Risk Reduction Strategy 2019-2030 approved by the Government of Tajikistan.

Adolescent and Youth

This sub-programme focus on enhancing the knowledge of young people on Healthy Life Style (HLS), as majority of young people has weak knowledge on CSE or HLS. Although 60 per cent of population is youth under age 24, the relatively high poverty level, limited economic opportunities, weak public services, and limited participation mean that they are unable to meet their potential and contribute to the country's development. Labour migration is the preferred livelihood strategy for young people; youth unemployment is high. According to the Demographic and Health Survey (2012), 7.4 per cent of adolescents aged 15-19 years had begun childbearing. Early marriages and childbearing among adolescents are more common in rural regions and poor families and for women with no or only primary education.

HIV prevention

This sub-programme contribute to the country response to AIDS is shaped by its mandate to reduce poverty, eliminate gender inequality and ensure universal access to sexual and reproductive health. As a co-sponsor of UNAIDS and under the UNAIDS division of labour, UNFPA focuses its response on HIV prevention among SW and MSM. Although HIV/AIDS emerged in Tajikistan relatively recently, the growing number of cases of HIV infection in the country is a cause for concern. Number of officially registered cases of HIV is 7,812 as of December 2018. Sexual transmission is now the dominant mode of HIV transmission and the epidemic remains concentrated among key populations (SW, MSM, PWID and prisoners) and their sexual partners. To prevent the spread of HIV in the country, Tajikistan's authorities have adopted several HIV prevention programmes. The establishment of the National Coordinating Committee for HIV/AIDS Prevention considerably slowed down the spread of the disease. Measures to deter the epidemic are implemented to a great extent with support from the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Gender equality and women's empowerment

The Government of Tajikistan committed to international treaties and pacts (UN CEDAW, UPR) including and adopted a number of legislative frameworks and strategies. Gender equality is considered as one of priority areas in the National Development Strategy and mainstreamed across all

national development goals. The Mid-term Development Programme defines the reduction of gender inequality as a standalone cross-sectoral priority.

UNFPA CO has initiated addressing GBV through strengthening of health system response to GBV. More than 400 service providers are trained within new programmes. Innovative demand creation activities through “Health Fairs” increased access of rural women and girls (more than 5000) to legal and health services.

Global Essential Service Package for women and girls subject to violence and Standard Operating Procedures (SOP) for health, police and social services on GBV prevention are introduced in the country. The MoHSP has adopted SOP for health sector. UNFPA/WAVE guidance “Strengthening of health system responses to gender-based violence” is integrated into educational programme of Reproductive health and Primary health care institutions.

Victim Support Rooms are institutionalized and considering effectiveness of this new innovative programme the MoHSP is expanding the experience in other regions involving development partners.

The Multi-Sectoral Cooperation Team (MSCT) to response to GBV is established. This coordination and advocacy platform promoted revision of the current Law on prevention of violence in the family in line with UPR and CEDAW recommendations. Multi-Sectoral Cooperation strengthened the referral system within different sectors and improved the response system.

Despite of policy support and efforts of GoT and developments partners Gender relations still are characterized by the persistence of practices and traditions, as well as patriarchal attitudes and deep-rooted stereotypes, on the roles, responsibilities and identities of women and men in all spheres of life.

According to recent 2017 DHS, 25% of married women age 15-49 were employed and among those, 74% were paid with cash only and 13% were not paid at all. The majority of employed women (71%) reported that they earn less than their husband. 42% of women age 15-49 report experiencing at least one problem in accessing health services. Getting money for treatment is the most commonly cited problem (35%). Less than half of married women age 15-49 have sole or joint decision-making power in their own health care, major household purchases, and visits to her family or relatives. One-third of married women participate in all three of those decisions, while almost half of married women participate in none of those decisions. About 24% women age 15-49 have ever experienced physical violence since age fifteen.

Population dynamics

This sub-programme support efforts to (a) advocate for and build in-country capacity for the integration of population dynamics, sexual and reproductive health, gender and youth concerns in national strategies and plans; (b) support the conducting of population surveys and analysis that contribute to evidence-based national policy formulation; (c) monitor, analyse and report progress on implementation of the post-2015 global development agenda by generating and disseminating sex and age disaggregated data on population dynamics, sexual and reproductive health and gender equality, including in humanitarian contexts; and (d) assist in preparations for the census 2020.

In addition, the sub-programme focuses on improvement of the Civil Registration and Vital Statistics (CRVS) system through contribution on realization of “Support to Civil Registration System Reform in Tajikistan” Project (Phase I) funded by the Government of Switzerland and implemented jointly by UNDP, UNFPA EPOS, and UN Women. With the aim to achieve the defined goal, UNFPA focus on both Project outcomes that represent the supply and demand sides of the CRVS services. The UNFPA contribute on four out of six Project outputs, namely: (i) Legislative framework for civil registration is compliant with international best practices; (ii) New internal regulations defining roles, responsibilities and processes are applied by civil registry offices and jamoats; (iii) Ministry of Justice makes use of new communication strategies to proactively incentivise the population to register their vital acts; (iv)

Outreach awareness rising campaigns by selected civil society organisations complement the Ministry of Justice communication strategies.

COUNTRY PROGRAMME

The 4th UNFPA Country Programme Document for Tajikistan (DP/FPA/CPD/TJK/4) has been approved by the UNDP/UNFPA/UNOPS Executive Board at its Annual session in New York on 31 August to 4 September, 2015. The UNFPA financial commitment over 5 years towards the programme was approved at \$5.0 million from regular resources (\$3.0 million for Sexual and reproductive health component, \$0,4 million for adolescents and youth component, \$0.7 million for population and development component, \$0.5 for gender equality component and \$0,4million for programme coordination and assistance). UNFPA also committed to mobilize \$2.2 million from other resources to co-fund the programme.

The country programme contributes to the national priorities outlined in the Medium-term Development Programme up to 2020 and National Development Strategy up to 2030. The programme is aligned with Sustainable Development Goals, UNFPA Strategic Plan 2014-2017, and the United Nations Development Assistant Framework (UNDAF) for Tajikistan 2016-2020. The country programme contributes to three out of six priority areas of the UNDAF in Tajikistan: (i) Good governance, rule of law and human rights; (ii) Social development, comprising health, education and social protection; and (iii) Inclusion and empowerment of vulnerable groups.

In line with the UNFPA business model, the programme has shifted to advocacy and upstream policy support, for strengthening institutional capacities, as well as implementation and accountability mechanisms within the national health system to deliver quality gender sensitive and client friendly reproductive health services with the focus on vulnerable groups. It also involves upstream policy engagement aimed at development of evidence-based programmes and plans in areas of gender, youth, and data and population.

The country programme aimed to deliver the following 6 outputs:

Output 1: Increased capacity of national institutions to deliver quality integrated sexual and reproductive health services that are enabled by strong policy framework.

Output 2: Strengthened national capacity to develop and regularly update contingency plans that address the sexual and reproductive health needs of women, adolescents and youth in crisis situations.

Output 3: Increased capacity of national institutions and networks to conduct evidence-based advocacy for incorporating adolescents and youth rights in national laws, policies and programmes.

Output 4: Increased participation of civil society organizations in promoting sexual and reproductive health and rights of vulnerable and marginalized youth groups.

Output 5: Strengthened capacity of institutions to enable delivery of multisectoral services and address gender-based violence and discrimination in line with international human rights treaties obligations.

Output 6: Strengthened national capacity to produce evidence and formulate national policies and strategies that integrate population issues.

ANNEXES:

Annex 1: 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:

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.

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.

Evaluations sometimes uncover suspicion of wrongdoing. Such cases must be reported discreetly to the appropriate investigative body.

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.

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

Annex 2: Evaluation Quality Assurance and Assessment: Tools and Guidance

<https://www.unfpa.org/admin-resource/evaluation-quality-assurance-and-assessment-tools-and-guidance>

Annex 3: How to Design and Conduct a Country Programme Evaluation at UNFPA

<https://www.unfpa.org/admin-resource/how-design-and-conduct-country-programme-evaluation-unfpa>

Annex 4: Equity-focused and gender-responsive lens evaluation

<https://www.evalpartners.org/evalgender/no-one-left-behind#guidance>

Signature of Requesting Officer in Hiring Office:

Date:

Annex 2: Stakeholder map

Focus area/sub-area	Stakeholders	Location
Output 1.1: Increased capacities of institutions to deliver integrated sexual and reproductive health services by strengthened evidence based policy frameworks and institutional mechanisms		
SRH/Maternity health	Ministry of Health	Dushanbe
	Republican teaching and clinical Center under the MoHSP	Dushanbe
	National RH Center	Dushanbe
	Oblast Health management departments	Kurgan-tube, Khatlon province Khujand, Sugdh province
	Oblast maternity houses	Kurgan-tube and Kulyab, Khatlon province
	City maternity house BTN, EPC	Khujand, Sugdh province
	District maternity houses - EPC	Khatlon and Sugdh provinces
	Oblast RH Centers	Khujand, Sugdh province Kulyab and Kurgan-tube, Khatlon province
	District RH Centers	Khatlon and Sugdh provinces
	Republican medical College	Dushanbe
	National coordinators of BTN	Dushanbe and Khujand, Sugdh province Kurgan-tube, Khatlon province
	Oblast Oncology center	Khujand, Sugdh province and Dushanbe
	Pathomorphological centers	Dushanbe, Khujand, Sugdh province
	Target districts for cancer screening	Bobojon Gafurov, Sugdh province Bokhtar, Khatlon province
	Emergency obstetric care	Dushanbe, Khujand, Sugdh province Bokhtar, Kulyab, Khatlon province Zaravshan
	Tajikistan Family Planning Alliance	Dushanbe
	USAID Feed the Future Programme - Health and Nutrition component	Dushanbe
GIZ - Maternal, neonatal and child health project	Dushanbe	
SRH/Family planning	Ministry of Health	Dushanbe
	National RH Center	Dushanbe
	Republican Teaching and Clinical Center of Family Medicine	Dushanbe
	Republican Medical College	Dushanbe
	Oblast Health management departments	Kurgan-tube, Khatlon province Khujand, Sugdh province
	Oblast RH centers	Sugdh , Khatlon (Kulyab, Bokhtar), Rasht, GBAO provinces
	District RH centers	Nationwide
	Tajik Family Planning Alliance	Dushanbe
SRH/ HIV prevention	Republican AIDS Center	Dushanbe
	NGO Apeiron	Dushanbe
	Trust Point at Sugdh oblast RHC (Rano)	Khujand, Sugdh province
	Trust Point Dushanbe (Firuza)	Dushanbe
	STI Center	Dushanbe
	Final beneficiaries: SWs and MSMs	Dushanbe

		Khujand, Sugdh province
Output 1.2: Strengthened national capacity to develop and regularly update contingency plans that address the sexual and reproductive health needs of women, adolescents and youth in crisis situations		
SRH	Emergency department of MoHSP	Dushanbe
	National and Oblast RH centers	Dushanbe, Sugdh, Khatlon, Rasht, GBAO
	Oblast Emergency management departments	Sugdh , Khatlon, Rasht, GBAO
	Tajik Family Planning Alliance	Dushanbe
Output 2.1: Increased capacity of national institutions and networks to conduct evidence based advocacy for incorporating adolescents and youth rights in national laws, policies and programmes		
Adolescents & Youth	NGOs - Y-PEER network members	Dushanbe, Kurgan-tube, Khatlon province Khujand, Sugdh province
	Ministry of Health	Dushanbe
	Medical Consultancy Centers for Youth (MCCY)	Dushanbe, Kurgan-tube, Khatlon province Khujand, Sugdh province
Output 2.2: Increased participation of civil society organizations in promoting sexual and reproductive health and rights of vulnerable and marginalized youth groups		
Adolescents & Youth	NGO partners working with vulnerable groups (SWs and MSMs)	Dushanbe, Kurgan-tube, Khatlon province Khujand, Sugdh province
	Trust Point at Sugdh oblast RHC (Rano)	Khujand, Sugdh province
	Trust Point Dushanbe (Firuza)	Dushanbe
	Final beneficiaries: SWs and MSMs	Dushanbe, Khujand, Sugdh province
Output 2.3: Increased capacity of schools to deliver healthy lifestyle education		
Adolescents & Youth	Ministry of education	Dushanbe
	NGO "Hamsol ba Hamsol" (YPeer)	Dushanbe
	Secondary school teachers trained in delivery of HLS course	Kurgan-tube, Khatlon province Khujand, Sugdh province
	Final beneficiaries: secondary schoolchildren taught HLS course	Kurgan-tube, Khatlon province Khujand, Sugdh province
	Education Academy	Dushanbe
	Teacher Training institute	Dushanbe
	Hired experts and consultants on development of HLS manual and its institutionalization	Dushanbe
	Hired experts and consultants on development of HLS manual and its institutionalization	Dushanbe
Output 3.1: Strengthened capacity of institutions to enable delivery of multisectoral services and to address gender based violence and discrimination in line with international human rights treaties obligations		
Gender	Committee on Women and Family Affairs (CWFA)	Dushanbe, Kurgan-tube, Khatlon province Khujand, Sugdh province
	Focal point for gender within Parliament	Dushanbe
	General Prosecutor Office	Dushanbe
	Ministry of Internal Affairs	Dushanbe, Kurgan-tube, Khatlon province

		Khujand, Sugdh province
	Committee on religion	Dushanbe, Kurgan-tube, Khatlon province Khujand, Sugdh province
	Ministry of Justice	Dushanbe
	Family medicine teaching centers/institutes	Dushanbe Kurgan-tube, Khatlon province Khujand, Sugdh province
	Victim Support Rooms within maternal hospitals	Dushanbe Guliston, Soghd province Bokhtar, Khatlon province
	NGO "Gender and Development"	Dushanbe
Output 4.1: Strengthened national capacity to produce evidence and to formulate national policies and strategies that integrate population issues		
Population and development	State Statistics Committee	Dushanbe
	National population and development committee	Dushanbe
	NGO Gender and Development	Dushanbe
	NGO ASTI	Khujand, Sugdh province
	UNDP, CRVS Project manager	Dushanbe
	Local authorities in target districts for CRVS project	Dushanbe Kulyab and Kurgantyube, Khatlon province Bobojon Gafurov and Rudaki districts, Soghd province

Annex 3: List of consulted persons

UNCT

Name	Position	Agency
Ms Nargis Rakhimova	Assistant Representative a.i. National Programme Analyst on RH	UNFPA
Mr Parviz Khakimov	National Programme Analyst on Population and Development	UNFPA
Mr Khurshed Irgitov	SRH Programme Associate	UNFPA
Mr Firuz Karimov	National Programme Officer, HIV/ Adolescents & Youth	UNFPA
Mr Pedro Pablo Villanueva	Former Country Director for Uzbekistan and Tajikistan	UNFPA
Mr Manuchehr Rakhmonov	Partnerships and Development Finance Analyst, RCO Focal Point	RCO
Ms Aziza Hamidova	Country Programme Manager	UN Women
Ms Tetyana Nikitina	Chief Monitoring & Evaluation	UNICEF

Sexual and Reproductive Health

Name	Position	Organisation	Location
Ms Jonova Bunafsha	Head of the Department of business planning and analysis of family medicine development	Republican Training and Clinical Family Medicine Center MoHSPP	Dushanbe
Mr Tahirov Ravshan	Head of the department of reforms management	MoHSPP	Dushanbe
Ms Ganizoda Munira	Director	National Reproductive Health Center	Dushanbe
Mr Ganieva Sarvinoz	Specialist	National Reproductive Health Center	Dushanbe
Ms Abdurahmanova Firuza	Head of Department of Obstetrics and Gynecology	Tajik State Medical University	Dushanbe
Ms Kamilova Marhabo	Head of Obstetrics department	Scientific research institute of Obstetric gynecology and perinatology	Dushanbe
Ms Murodalieva Bunafsha	Head of Analytical and Education department	National Reproductive Health Center	Dushanbe
Mr Vasihov Shokirjon	Head of department of pathomorphology	Oncology center	Dushanbe
Ms Saburi Parvina	Cytologist	Oncology center	Dushanbe
Ms Masaidova Lola	Pathomorphologist	Oncology center	Dushanbe
Ms Zarina Akhmedova	Colposcopist/ gynecologist	Oncology center	Dushanbe
Mr Salohiddin Saibov	Acting Director	Tajik Alliance of Family Planning	Dushanbe
Ms Parvina Ghiyasova	Director	NGO "Aiperon"	Dushanbe
Ms Zarrina Tajibaeva	Deputy Director	NGO "Aiperon"	Dushanbe

Ms Saidakhmadova Shahlo	Head of Department of Obstetrics and Gynecology	State educational institution Republican Medical College	Dushanbe
Khatlon province			
Mr Gayurov I.	Head of DOH	Kulyab DOH	Kulyab
Mr Mirzoev Iskandarsho	Chief Specialist	Kulyab DOH	Kulyab
Ms Nargiz Khamidova	Director	Kulyab Reproductive Health Center	Kulyab
Ms Mamadova Khursanbi	Colposcopist gynecologist	Kulyab Reproductive Health Center	Kulyab
Mr Ahmadzoda Suman	Gynecologist	Kulyab Reproductive Health Center	Kulyab
Mr Saidaliev Tolib	Director	NGO Sudman	Kulyab
Mr Kholnazarov Davlat	Health worker	District Health Center	Kulyab district
Ms Jalilova Fazilat	Chief nurse	District Health Center	Kulyab district
Ms Ismatzoda Roziya	Director	Kulyab District Reproductive Health Center	Kulyab district
Ms Gafurova Husniya	Head of Maternity Ward of CDH	Kulyab District Central District Hospital	Kulyab district
Ms Qurbonova Naasiba	Ob/gyb	Kulyab District Central District Hospital	Kulyab district
Mr Sugonov Asadullo	Neonatologist	Kulyab District Central District Hospital	Kulyab district
Ms Nabieva Nargis	Midwife	Village Health Center (Khakimov)	Kulyab district
Ms Mirzoeva Raihona	Director	Khatlon Oblast Reproductive health center	Bokhtar
Ms Kambarova Zebo	Colposcopist/ gynecologist	Khatlon Oblast Reproductive health center	Bokhtar
Ms Ubaidulloeva Nigina	Ob/gyn	Khatlon Oblast Reproductive health center	Bokhtar
Ms Zaripova Gulbahor	Director	Bokhtar city Reproductive health center	Bokhtar

Ms Rajabova Ulmasoi	Ob/gyb	Bokhtar city Reproductive Health Center	Bokhtar
Ms Sharipova Maidagul	Deputy of Chief Doctor	Khatlon Oblast Central Hospital	Bokhtar
Ms Azizova Oksana	Ob/gyb	Khatlon Oblast Central Hospital	Bokhtar
Ms Razakova Nodira	Chief ob/gyns	DOH	Bokhtar
Mr Saidov Ilhom	Manager	Kushoniyon PHC	Kushonoyon district
Ms Odilova Gulnigor	Director	District Reproductive Health Center	Kushonoyon district
Mr Toirov	Deputy PHC Manager	Kushoniyon PHC	Kushonoyon district
Ms Muminova Firuza	Head of Maternity ward of CDH	Kushoniyon CDH	Kushonoyon district
Ms Homidova Mukarram	Midwife	Village Health Center Navkor	Kushonoyon district
Ms Ibragimova Hanifa	Midwife	Village health Center Navkor	Kushonoyon district
Mr Rahimjonov Ismoil	Director	Village Health Center Navkor	Kushonoyon district
Ms Nabotova Firuza	Ob/gyb	Village Health Center Yangi-yul	Kushonoyon district
Ms Murodovana Mavluda	Director	Khatlon Oblast Training and Clinical Family Medicine Center	Kushonoyon district
Sughd province			
Mr Obidi Farhod	Manager	Central District Hospital	Istaravshan district
Mr Bobojoniyon Rahmon	Manager	PHC	Istaravshan district
Ms Boboeva Gulchehra	Head of Maternity Ward of CDH	Central District Hospital	Istaravshan district
Ms Karimova Firuza	Director	Reproductive Health Center	Istaravshan district
Ms Rustamova Rano	Chief ob/gyns	DOH	Khujand
Ms Mehmonova Rano	Director	Oblast Reproductive Health Center	Khujand
Ms Samieva Natalya	BTN Coordinator	Khujand city Maternity House	Khujand
Ms Aminova Zarrina	Director	Reproductive Health Center	Bobojon Gafurov district
Mr Juraev Murod	Head Doctor	Central District Hospital	Bobojon Gafurov district
Ms Ibragimova Hamida	Deputy Chief Doctor	Central District Hospital	Bobojon Gafurov district

Ms Sultonova Nargis	Midwife	Health House	Bobojon Gafurov district
Ms Temirova Shahodat	Ob/gyb	Health House	Bobojon Gafurov district
Ms Sadikova Munira	Director	Sugdh Oblast Training and Clinical Family Medicine Center	Khujand
Ms Rizoeva Dildora	Deputy Director	Sugdh Oblast Training and Clinical Family Medicine Center	Khujand
Ms Buzurukova Shoira	Chief Doctor	Oblast Marenity House	Khujand
Ms Azimova Dilrom	Ob/gyn, BTN Coordinator	Oblast Marenity House	Khujand
Ms Sanginova Malika	Director	City Reproductive Health center	Khujand
Ms Nasirova Dilrom	Director	Reproductive Health center	Spitamen district
Ms Boboeva Rafoat	Family Advisor	Women's Affairs Committee	Khujand

Adolescents and Youth

Name	Organization/Position	Location
Mr Saidashraf Hasanov	Center for Continuing Education	Dushanbe
Ms Parvina Sulaimoni	NGO "Hamsol ba Hamsol"	Dushanbe
Ms Saida Munieva	Center for prevention and response to sexually transmitted diseases	Dushanbe
Ms Parvina Ghiyasova	NGO "Aiperon"	Dushanbe
Ms Zarrina Tajibaeva	NGO "Aiperon"	Dushanbe
Khatlon province		
Ms Nisoeva Rukhsoramo	HLS teacher from secondary school #5	Kulyab
Ms Amirova Shamsiya	HLS teacher from secondary school #2	Kulyab
Ms Rasulova Mehribon	HLS teacher from secondary school #6	Kulyab
Ms Ishokova Daliafruz	HLS teacher from secondary school #52	Kulyab
Ms Safarova Rafoat	HLS teacher from secondary school #30	Kulyab
Ms Nigina Ubaidulloeva	Manager of youth friendly center within RHC	Bokhtar
Mr Rustam Bahridinov	Director of NGO "Fidokor" (MSM and SW focus)	Bokhtar
Ms Safarova Zebo	HLS teacher from secondary school #5	Bokhtar
Ms Nozimova Sadbarg	HLS teacher from secondary school #10	Bokhtar
Ms Gulova Zebunisso	HLS teacher from secondary school #10	Bokhtar
Sugdh province		
Ms Samirboeva Marhamat	HLS teacher from secondary school #28	Bobojon Ghafurov

Ms Nadirova Halima	HLS teacher from secondary school #12	Bobojon Ghafurov
Ms Mirpochoeva Ibodat	Specialist of local education branch	Bobojon Ghafurov
Ms Mutabar Khojaeva	HLS teacher from secondary school #4	Khujand
Ms Haidarova Sadbarg	HLS teacher from secondary school #9	Khujand
Ms Kasimova Rano	Project coordinator, NGO "Sadoqat"	Spitamen

Gender

Name	Organization/Position	Location
Mr Tohirov Jamshed	MoHSP, Head of International Department	Dushanbe
Ms Jonova Bunafsha	Republican Training and Family Medicine Center	Dushanbe
Ms Saidova Nargis	Head, NGO "Gender and Development"	Dushanbe
Khatlon province		
Mr Ahmadzoda Suman	District reproductive health center	Kulyab
Ms Sidikova Manzura	Focal point "Victims Support Room", materniy hospital	Kulyab
Ms Sangova Madina	Inspector on GBV, Kulyab police department	Kulyab
Ms Mirzoeva Raihona	Head, district reproductive health center	Bokhtar
Ms Kambarova Zebo	Staff member of district reproductive health center	Bokhtar
Ms Rustamova Maidagul	Focal point "Victims Support Room", maternity hospital	Bokhtar
Sughd province		
Ms Gadoeva Gulchehra	Head of maternal hospital	Istaravshan
Ms Salimova Soima	Deputy of chief doctor	Istaravshan
Ms Sobirova Zulkhumor	Head of the emergency department and infants intensive therapy	Istaravshan
Ms Obidova Khurhseda	Responsible person for audit of critical cases	Istaravshan
Ms Aizemova Hukminisso	Neonatal specialist	Istaravshan
Ms Saidov Umar	Neonatal specialist/breastfeeding department	Istaravshan
Hakimov Shohkarim	Family doctor, Medical center, Obodi village	Istaravshan
Ms Ashurova Khursheda	Reproductive health specialist, medical center, Obodi village	Istaravshan
Ms Ismoilova Rano	Deputy head of the regional department for health	Khujand
Ms Hasanova Nargis	Focal point, Victims Support Room, maternal hospital	Khujand
Ms Sodikova Munirakhon	Head, Oblast Training and Clinical Family Medicine Center	Khujand
Ms Mirzoeva Dildora	Deputy Head, Oblast Training and Clinical Family Medicine Center	Khujand
Ms Nasirova Dilrom	Head, Reproductive Health Center	Spitamen

Population and Development

Name	Position	Organisation	Location
Mr. Rizoiev Najmiddin	Deputy of population census management	Agency on statistics under the President of RT	Dushanbe
Mr. Rajabov Tagabek	Head of department of population census and housing	Agency on statistics under the President of RT	Dushanbe
Mr. Jumaev Firdavs	Key specialist	Agency on statistics under the President of RT	Shohmansur district, Dushanbe
Mr. Kurbonov Fayzali	Specialist in population census and housing	Agency on statistics under the President of RT	Firdavsi district, Dushanbe
Mr. Shahriyori Ibrohim	Specialist in population census and housing	Agency on statistics under the President of RT	Sino district, Dushanbe
Mr. Davlatzoda Sabiddin	Director	Agency on statistics under the President of RT	Rudaki district, DRD
Mr. Norov Hujamurod	Main specialist	Agency on statistics under the President of RT	Rudaki district, DRD
Mr. Tagoev Firuz	Head of department of population census	Agency on statistics under the President of RT	Rudaki district, DRD
Mr. Yakubov Bahtovar	Specialist	Agency on statistics under the President of RT	Rudaki district, DRD
Ms. Nargis Saidova	Chief Executive officer	NGO «Gender and development»	Dushanbe
Ms. Nigina Mahmudova	Accountant	NGO «Gender and development»	Dushanbe
Ms. Bozrikova Tatyana	Gender expert	NGO «Gender and development»	Dushanbe
Mr. Karimov Alisher	Project manager, CRVS Project	UNDP in Tajikistan	Dushanbe
Mr. Sodikov Farhod	Project coordinator, CRVS Project	NGO «ASTI» (Association of scientific and technical intelligentsia of Tajikistan)	Rudaki district, DRD
Ms. Hayrinisso Yusufi	National Council on Population and Development	Deputy of Majlisi Namoyandagon Majlisi Oli	Dushanbe
Mr. Samadzoda Iftihor	Deputy chief of registry office	Ministry of Justice of RT	Dushanbe
Mr. Kabilov Bahtier	Head of department of legal ensuring of international cooperation and participation of the Republic of Tajikistan in international organisation	Ministry of Justice of RT	Dushanbe
Mr. Malikov Tavakkal	Head of social sectors development management	Ministry of economic development and trade of the RT	Dushanbe
Khatlon province			
Mr. Safarov Manuchehr	Director	Agency on statistics under the President of RT	Kulyab
Mr. Kurbonov Abduholik	Head of department of population census	Agency on statistics under the President of RT	Kulyab
Mr. Yahshibekov Majnun	Project manager assistant, CRVS Project	NGO «ASTI» (Association of scientific and technical intelligentsia of Tajikistan)	Kulyab
Mr. Sultonov Abdugafar	Director	Agency on statistics under the President of RT	Bohtar

Mr. Safarov Hasan	Main specialist on population census	Agency on statistics under the President of RT	Bohtar
Ms. Amireva Badahshon	Director	Agency on statistics under the President of RT	Kushoniyon district
Mr. Muhiddinov Davlat	Head of department of population census and housing	Agency on statistics under the President of RT	Kushoniyon district
Mr. Zoirov Ilhom	Director	Agency on statistics under the President of RT	Huroson district
Mr. Amiraliev Sangimahmad	Main specialist on population census and housing	Agency on statistics under the President of RT	Huroson district
Sughd province			
Ms. Anvarova Surayo	Director	Agency on statistics under the President of RT	Istaravshan
Mr. Bafoev Muhammadi	Head of department of population census	Agency on statistics under the President of RT	Istaravshan
Mr. Islomiddin Sadridin	Director	Agency on statistics under the President of RT	Khujand
Mr. Rabiev Abdumutalib	Head of department of population census	Agency on statistics under the President of RT	Khujand
Mr. Kosimi Hurshed	Director	Agency on statistics under the President of RT	Bobojon Gafurov district
Mr. Ashurov Mahkamboy	Head of department of population census	Agency on statistics under the President of RT	Bobojon Gafurov district
Mr. Gadoyboev Mahmud	Head of department of population census	Agency on statistics under the President of RT	Spitamien district
Ms. Turaeva Muhbira	Director	NGO «ASTI» (Association of scientific and technical intelligentsia of Tajikistan)	Khujand
Ms. Saidova Surayo	Project coordinator	NGO «ASTI» (Association of scientific and technical intelligentsia of Tajikistan)	Khujand
Ms. Ganieva Nasiba	Coordinator assistant	NGO «ASTI» (Association of scientific and technical intelligentsia of Tajikistan)	Bobojon Gafurov district

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Annex 5: Evaluation Matrix

EQ1. To what extent is the UNFPA support			
<p>(i) adapted to the needs of the population with emphasis to the most vulnerable population,</p> <p>(ii) in line with the priorities set by ICPD Plan of Action and national policy frameworks related to UNFPA mandated areas,</p> <p>(iii) aligned with the UNFPA strategic plan, in particular Strategic plan principles (leaving no one behind and reaching the furthest behind), transformative goals, and business model, and</p> <p>(iv) aligned with the UN Partnership Framework?</p>			
Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
A1.1. UNFPA support through the CP is adapted to the needs of the population with emphasis to the most vulnerable population.	<ul style="list-style-type: none"> Evidence that the needs of the population in general and needs of the most vulnerable population groups, were analyzed to inform the design of CP 2016-2020. 	<ul style="list-style-type: none"> CPD AWPs, COARs UNCEF Adolescents Baseline Study, 2019 DHS statistics for Tajikistan from 2012 and 2017 State statistics on men and women CEDAW and UPR recommendations for Tajikistan Common Country Assessment Report 	<p>Document review</p> <p>Interviews with:</p> <ul style="list-style-type: none"> UNFPA CO staff Implementing partners CP Beneficiaries

- **CP design was informed by the analysis of the population needs in UNFPA focus areas.**

CP design was informed by the situation analysis that paid explicit attention to the needs of population, and explicit emphasis on the most vulnerable population. Situation analysis section in the CPD explicitly talks about shortage of health professionals in rural regions; declines in contraceptive use, mainly for women aged 15 - 24 years who have limited knowledge of reproductive health and rights and are subject to family pressures; early marriages and childbearing among adolescents being more common in rural regions and poor families and for women with no or only primary education; sex workers and men who have sex with men being most at HIV infection risk population groups. There is also analysis of the maternal mortality trends and reasons and growing cervical cancer morbidity. All these issues were addressed within the CP.

- **UNFPA supported assessments which produced recommendations on adaptation of UNFPA support to needs of the population, including to the most vulnerable groups.**

For example, in 2017 UNFPA supported an assessment of accessibility and quality of health services to key populations (SWs and MSMs) at the level of primary health institutions implemented in collaboration with the Republican Training and Family Medicine Center. Assessment engaged both health professionals and representatives of key populations and provided recommendations for future work. The study on access to civil registration conducted by NGO “Gender and Development” focused on assessing and analyzing the situation of the most vulnerable group of women i.e. women living with disabilities, women parenting children alone, women heading households, families, including wives of labor migrants. Study results informed design on the activities conducted within the CRVS project, including mobile consultation and information campaign reaching to vulnerable groups.

- **National stakeholders and CP beneficiaries think that UNFPA support through the CP is well adapted to the needs of the target populations.**

For example, evaluation respondents think that HLS courses promoted within the framework of the Adolescents and Youth component are a relatively accessible venue for adolescents to learn about SRH, share their concerns and questions, especially because adolescents are not always able to receive this information from parents both due to traditional conservative views and a large number of parents being abroad as labor migrants: “Considering the situation with high number of male labor migration, including adolescent boys and youth, HLS courses are very relevant for boys as well” (Teacher of HLS courses).

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
A1.2. UNFPA support through the CP is in line with the priorities set by ICPD Plan of Action and national policy frameworks related to UNFPA mandated areas	<ul style="list-style-type: none"> • Evidence that the priorities set by ICPD Plan of Action and national policy frameworks related to UNFPA mandated areas were used to inform the design of CP 2016-2020 	<ul style="list-style-type: none"> • ICPD • CPD • COARs 	Document review Interviews with: <ul style="list-style-type: none"> • UNFPA CO staff • Implementing partners • CP Beneficiaries

- CPD explicitly says that the 2016-2020 Country Programme “is grounded in the principles of the International Conference on Population and Development (ICPD)”.
- Activities implemented within the framework of the CP are in line with 11 out of 15 key areas for action identified by the Framework of Actions for the follow-up to the Programme of Action of the International Conference on Population and Development Beyond 2014 (see Table below).

Thematic pillars	Key areas for future action	Examples on CP interventions that are in line with the priorities set in the Framework of Actions for the follow-up to the Programme of Action of the International Conference on Population and Development Beyond 2014
Dignity and human rights	1. Addressing economic inequalities.	-
	2. Empowerment of women and girls and elimination of all forms of violence.	<ul style="list-style-type: none"> • UNFPA supports operation of the GBV support rooms at the regional maternity clinics. • The Republican Training and Family Medicine Center conducted ToTs on gender sensitive health services for trainers of regional training centers on family medicine, specifically on detecting gender-based violence cases during provision of health services by family doctors providing consultations and medical services for victims and referral of GBV victims for further assistance. Modules on gender-based violence are mainstreamed into the regular training programs of the Training and Family Medicine center. • Standard operational procedures for health sector professionals have been developed with the technical support from UNFPA and have been approved by the Ministry of Health for further mainstreaming. The SOPs include standards for response to violence against both women and underage girls. • Staff of the visited reproductive health centers have undergone gender training and response to GBV supported by the programme. • UNFPA supported the establishment of the Multi-sectoral working group within the framework of the “Law on Prevention of Domestic Violence” which is operational and is working towards strengthening inter-agency referral network of GBV cases.
	3. Investment in the capabilities of children and youth.	-
	4. Eliminate discrimination and marginalization.	<ul style="list-style-type: none"> • In 2016-2017 the CP supported outreach work that facilitated access to HIV testing and SRH service to SWs and MSMs that are among the most marginalized groups of population in Tajikistan.
Health	1. Accelerate progress towards universal access to quality sexual and reproductive health services.	<ul style="list-style-type: none"> • In 2016 the CP supported the assessment of the quality of SRH services provided by the primary health care centers conducted by the Republican Training and Family Medicine Center. Assessment covered provision of family planning services, antenatal care, services to adolescent, prevention of STIs and HIV, prevention of cervical cancer, prevention of GBV. Results and recommendations of this assessment were presented

		<p>to the Ministry of Health and development partners leading to the development of the Action plan.</p> <ul style="list-style-type: none"> • The CP supported training for midwives and doctors from remote rural areas on modern contraceptive methods to increase access to these methods for rural population. • The CP supports Health Caravan to rural areas providing local residents an opportunity to get access to high quality SRH services.
	2. Protect and fulfil the rights of adolescents and youth to SRH education and health services.	<ul style="list-style-type: none"> • HLS course developed and introduced to 260 schools with the CP support offers adolescents an opportunity to learn about SRH, share their concerns and questions. • CP supports mobile outreach events that are organized once per year and gather adolescent girls in the regions, engaging them in three hours interactive information sessions on reproductive health issues. • CP supported development of a mobile app for adolescents that provides access to quality SRH information.
	<p>3. Strengthen specific SRH services, including:</p> <ul style="list-style-type: none"> • Access to widest possible range of contraceptive methods; • Access to safe abortion and post-abortion care; • Elimination of all preventable maternal deaths; • Increased access to effective prevention, diagnosis and treatment of STIs, including HIV, for all persons, particularly young people, • Address the rising burden of reproductive cancers, including breast, cervical and prostate cancers. 	<ul style="list-style-type: none"> • UNFPA supports procurement of contraceptives which ensures access of women throughout the country to a wide range of contraceptive methods. All health centers visited by the evaluation team had on stock condoms, IUDs, oral and injection contraceptives. • UNFPA continues support to application of the near miss cases review methodology introduced in the country in 2012. • In 2016-2017 through the HIV Prevention Programme the CP supported facilitation of SWs and MSMs (including young SWs and MSMs) access to regular HIV testing and SRH services. • UNFPA implemented a pilot project that resulted in almost full coverage of eligible women with cervical cancer screening in two pilot districts. • The CP supported training on cervical cancer screening to SRH specialists in selected districts.
Place and mobility	1. Recognize and account for the increasing diversity of households and living arrangements.	-
	2. Plan and build sustainable cities.	-

	3. Make migration work for development and ensure rights and security for migrants.	<ul style="list-style-type: none"> Teachers who already deliver the HLS courses think that the information on HIV and STIs prevention is very useful for boys who often become labor migrants right after graduation and get exposed to higher risk of contracting HIV and STIs when abroad.
	4. Greater attention to those without security of place, including those displaced by conflict or natural disasters.	<ul style="list-style-type: none"> In 2016 UNFPA supported development of the National Action Plan for SRH in Crisis approved by the MoHSP. The CP supports trainings on Minimum Initial Service Package (MISP) and addressing the sexual and reproductive health needs of women, adolescents and youth.
Governance and accountability	1. Invest in capacity to monitor and project population dynamics.	<ul style="list-style-type: none"> In 2016 UNFPA supported participation of specialists of the MEDT and the Statistic Agency in Population Development and Population Projection trainings.
	2. Strengthen knowledge sectors, including: <ul style="list-style-type: none"> Increase the number and quality of human resources; Integrating new methods and technologies; Strengthening civil registration and other administrative data sources, as well as migration statistics; Disseminating data and democratizing data use; and Making sure that population data inform policy decisions. 	<ul style="list-style-type: none"> The CP supported development of the capacity of the staff of the Statistics Agency in preparation to the Census 2020, including introduction of the use of modern digital technologies, e.g. tablets and online surveys. Through the CRVS project UNFPA supported strengthening of the national CRVS system and supported residents of remote areas with getting birth certificates for their children.
	3. More systematic, inclusive participation	<ul style="list-style-type: none"> In 2016 the CP supported the Y-PEER network to organize a meeting of Tajikistan Parliament member with more than 200 students of Medical College of Khujand to discussion SRH and gender equality issues. The CP supports networks of NGOs providing services to SWs and MSMs to promote effective service models to the state, including organization of round tables bringing together NGO and government specialists.
	4. Better accountability systems, including public access to population data.	<ul style="list-style-type: none"> In 2016 UNFPA supported update of the TojikInfo online database that allows users to measure and analyze poverty level and social status of population, change in demographic trends, population health status and mapping of social inequality.

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
A1.3. UNFPA support through the CP is aligned with the UNFPA strategic plan, in particular Strategic plan principles (leaving no one behind and reaching the furthest behind), transformative goals, and business model	<ul style="list-style-type: none"> Evidence of CP design and implementation alignment with the UNFPA strategic plans 2014-2017 and 2018-2021, including principles (leaving no one behind and reaching the furthest behind), transformative goals, and business model 	<ul style="list-style-type: none"> UNFPA SP 2014-2017, 2018-2021 CPD AWPs, COARs IP reports 	<p>Document review</p> <p>Interviews with:</p> <ul style="list-style-type: none"> Implementing partners CP beneficiaries (youth and adolescents in general, excluded population among youth)

Reaching the furthest behind/ Leaving no one behind

UNFPA has explicit focus on reaching the furthest behind, but the reach of its interventions is limited.

Within the CRVS project UNFPA supported the assessment of accessibility of civic registry services for vulnerable groups of population, including labor migrants, single mothers and people with disabilities. The study helped to identify villages with the lowest level of awareness and knowledge about civic registration service. These villages were targeted by interventions, including forum theatre information campaigns and mobile consultations. But these interventions were implemented only in selected villages in four pilot districts.

CP supported training of IUD insertion for midwives from remote villages. Villages were selected by national and regional health authorities based on the data on the use of contraceptives. Training was provided for midwives from villages with the lowest rate of contraceptive use. In Khatlon region in 2017-2019 CP supported training for 35 midwives from remote villages. According to regional RH specialists after the training use of IUD in the villages where trained midwives work increased.

Cervical cancer: a pilot project made every effort to reach to all eligible women in two target districts (including preparation of individual invitations), but women in the other 68 regions did not get any benefits. Other districts that have specialists trained by the CP don't do massive screening campaigns.

GBV victim support rooms – there is no evidence that they were used by women from remote areas.

Health Fairs (Health Caravans) – UNFPA brings ob-gyns, psychologists and legal advisors to villages (selected in consultation with regional and district authorities). For example, in 2019 Health Fair was conducted in Zargar, Kushonion district of Khatlon region, and reached 400 women. “Zargar was selected because this is the largest jamooat (municipality) in the district”. In Istaravshan district in 2018 Health Fair was conducted in Obodi village. Local community is very religious and the use of SRH services was low. Obodi village was selected by regional health authorities based on the information about existing problems provided by the districts.

UNFPA is the only agency working with MSMs. “In 2014 when authorities started prosecuting sex workers, UNFPA was the only agency that agreed to advocate for provision of services to SWs at the national level” (Implementing partner). When UNFPA supported provision of services to SWs and MSMs, the reach was about 10%.

Introduction of HLS course. Teachers who are class coordinators have to deliver nine HLS session to students in their classes in the course of the school year. Hence training of HLS course is relevant to many teachers in a school. Yet the CP provided training only to one teacher per school.

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
A1.4. UNFPA support through the CP is aligned with the UN Partnership Framework	<ul style="list-style-type: none"> Evidence of CP alignment with UNDAF 	<ul style="list-style-type: none"> UNDAF CPD 	Document review Interviews with: <ul style="list-style-type: none"> UNFPA CO staff Implementing partners UNCT members, including RC, UNICEF, WHO, UNDP, UNAIDs

CP was well aligned with the initial version of UNDAF results framework adopted in December 2015:

- The SRH component of the CP was contributing to UNDAF Indicator 3.9. Maternal mortality ratio (per 100,000 live birth) under UNDAF outcome 3: People in Tajikistan benefit from quality, equitable and inclusive health, education and social protection systems. In addition, UNFPA efforts to strengthen national capacity to develop and regularly update contingency plans that address the sexual and reproductive health needs of women, adolescents and youth in crisis situations (output 2 under SRH component) were contributing towards achievement of UNDAF Indicator 6.6. Number of disaster impact alleviation plans and policies (at all levels) under UNDAF outcome 6: People in Tajikistan are more resilient to natural and man-made disasters and benefit from improved policy and operational frameworks for environmental protection and sustainable management of natural resources.

- The Youth component of the CP was contributing to UNDAF Indicator 3.14 Percentage of young women and men aged 15-24 years who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission under UNDAF outcome 3: People in Tajikistan benefit from quality, equitable and inclusive health, education and social protection systems.
- The Gender component of the CP was contributing to UNDAF Indicator 5.2. Gender Gap Index under UNDAF outcome 5: Women, youth, children, persons with disabilities and other vulnerable groups are protected from violence and discrimination, have a voice that is heard and are respected as equal members of society.
- The P&D component of the CP was contributing to UNDAF Indicator 1.5. New national development strategies are developed based on human rights, accurate evidences and consider accepted international development frameworks (SDG, ICPD, CEDAW etc.) under UNDAF outcome 1: People in Tajikistan have their rights protected and benefit from improved access to justice and quality services delivered by accountable, transparent and gender-responsive legislative, executive and judicial institutions at all levels.

The extent of CP alignment with the new UNDAF results framework is partial because many indicators reflecting UNFPA contribution were dropped.

In 2017-2018 UNCT undertook a series of reviews and assessments to improve the measurability and evaluability of the UNDAF⁵². This work resulted in stronger UNDAF results framework, encompassing a set of high quality, measurable UNDAF outcome indicators made effective in 2019. But this new framework does not include indicators measuring maternal mortality, knowledge about HIV among young people, Gender Gap Index and number of new development strategies. At the same time several indicators directly related to UNFPA worked were added: Indicator 3.15 Contraceptive prevalence rate (SDG 3.7.1), Indicator 5.1 Presence of new or strengthened legal and policy frameworks to promote, enforce and monitor gender equality and non-discrimination, including GBV and SRH, in line with international standards (SDG 5.1.1); Indicator 5.6. Number of civil society networks engaged in programmes that address sexual and reproductive health needs of women, youth, children, persons with disabilities and other vulnerable groups, including refugees and stateless persons (→SDG 3.8.1, 17.17); Indicator 5.7. Extent of implementation of legal and policy frameworks that address gender-based violence (GBV), including intimate partner and domestic violence, in line with international standards (→SDG 5.2.1, 5.2.2).

CP is well aligned with priority approaches emphasized in the UNDAF document.

UNDAF document highlights that application of comprehensive capacity development approach (at systemic, institutional and organizational levels) should be a crosscutting principle used by all UN agencies. UNFPA was consistently using this approach within the CP: all four CP components included training activities for national stakeholders.

UNDAF document also says that UNCT support shall place emphasis on awareness and assumption of responsibility by authorities in constructive coordination with the civil society partners for assessing, prioritizing and responding to the needs of those who are most vulnerable, socially excluded and/or disadvantaged and at risk of being left behind as the country progresses. Under the Youth component of the CP UNFPA supported establishment and operation of NGO networks

⁵² A Strengthened Results Framework for the United Nations Development Assistance Framework (UNDAF) for Tajikistan. Final Report (2019).

working with SWs and MSMs who are highly vulnerable to HIV infection and at the same time socially excluded as well as efforts of these networks to engage with authorities to promote service delivery models responsive to the needs of SWs and MSMs.

EQ2. To what extent have the intended programme outputs been achieved? EQ3. 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 gender equality, and iv. developing of evidence-based national population policies) and what was the degree of achievement of the outcomes?			
Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
A2.1. CP has achieved intended outputs and outcomes in the SRH focus area	<ul style="list-style-type: none"> Evidence of achievement of intended outputs Evidence of achievement of intended outcomes 	<ul style="list-style-type: none"> CPD AWPs, SPRs, COARs Monitoring reports Policy documents developed with UNFPA support Report on the evaluation of cervical cancer project 	Document review Interviews with: <ul style="list-style-type: none"> UNFPA CO staff Implementing and national partners Targeted health institutions in Dushanbe, Khatlon and Sugdh provinces CP Beneficiaries

The CP has reached all targets for its outputs and outcomes in the Sexual and Reproductive Health focus area.

Output 1: Increased capacities of institutions to deliver integrated sexual and reproductive health services by strengthened evidence based policy frameworks and institutional mechanisms.

Indicator	Baseline	Target	Actual
Number of new national plans and policies that prioritize universal access to sexual and reproductive health.	0	3	3
Number of new guidelines, protocols and standards for health-care workers developed for delivery of integrated age and gender-responsive sexual and reproductive health services (including on cervical cancer).	1	4	4
Percentage of primary health-care facilities in pilot region providing integrated sexual and reproductive health services (including cervical cancer screening).	0%	30%	100% (in pilot regions)

Maternal death surveillance and response system established and operational at national level.	No	Yes	Yes
Percentage of service delivery points providing at least three types of contraceptives.	65%	85%	85% (2018, MoHSP)

Output 2: Strengthened national capacity to develop and regularly update contingency plans that address the sexual and reproductive health needs of women, adolescents and youth in crisis situations.

Indicator	Baseline	Target	Actual
Number of new or revised national and regional humanitarian contingency plans that include elements of Minimum Initial Service Package and address the sexual and reproductive health needs of women, adolescents and youth in crisis Baseline: 1; Target: 4	1	4	4 (2018)

Outcome: Sexual and reproductive health Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access.

Indicator	Baseline	Target	Actual
Maternal mortality ratio (per 100,000 live births) Baseline: 33; Target: 25	33	25	24 (2018, MoHSP)
Contraceptive prevalence rate (modern) Baseline: 30%; Target: 37%	30%	37%	40,1% (2018, MoHSP)
Percentage of sex workers who have received an HIV test in the past 12 months and know their results Baseline: 55,7%; Target 70%	55,7%	70%	70%

UNFPA CO contributed to the development a number of national strategic documents:

- National Development Strategy up to 2030;
- Medium-term Development Programme for 2016-2020;
- National action plan on Reproductive, Maternal, Newborn, Child and Adolescence health (2016);
- Health code of Tajikistan (2017);
- Strategic plan for the development of family medicine-based primary health care in the Republic of Tajikistan (2016–2020);
- National Program on SRH for 2019-2022;
- National Communication Strategy on SRH;
- National HIV prevention programme 2018-2021;
- Comprehensive Health Strategy for the period of 2020-2030.

UNFPA supported assessments of quality of services for mothers and newborns at the hospital and PHC levels using WHO tools. These assessments helped the Ministry of Health and Development Partners to identify key areas for improvement. UNFPA long term and systematic approach to reorganization of MCH services

according to effective perinatal care technologies, introduction of national standards, clinical protocols and near-miss cases review and their implementation in maternity clinics was instrumental in terms of reducing maternal and neonatal mortality and morbidity.

UNFPA is leading agency in introduction of Effective Perinatal Care (EPC) programme and Beyond the Number (BTN) in Tajikistan since 2008. UNFPA supported introduction of updated EPC package, new training programme on EmOC and clinical protocols on resuscitation in obstetrics at the national and regional levels followed by monitoring and supportive supervision. This package is highly appreciated by national partners as one of important tool for improving quality of care and reduction of maternal and newborn morbidity and mortality. During supervisory visits, special attention was given to developing facility-based plans for improvement of clinical emergency obstetrics practices, identification of measurable indicators and improvement of management and teamwork of health facilities, which has resulted in a significant reduction in the use of general anesthesia methods and reduction in eclampsia and postnatal bleeding at the national and province levels.

Stakeholders repeatedly cited the importance of UNFPA support for the roll-out of the WHO “Beyond the numbers” methodologies in identifying priority interventions to help reduce maternal mortality. Due to the implementation of mentioned methodology the quality of EmOC improved, internal protocols are developed and in place. This facilitated the MoHSP with development of the National Guideline on Perinatal audit. Nevertheless, near-miss cases review is fully operational in 20 maternity clinics piloted and supported by UNFPA out of 36 total second and third level pilot maternity clinics supported by other development partners (DPs), which requires additional joint work with DPs on addressing challenges towards achievement of strategic goal to end all preventable maternal deaths.

Visited maternity houses implementing both NMCRs and EPC have positive results in quality of services: increase of facility-based deliveries and skilled birth attendance, decrease of earlier and post-delivery bleedings, uterus rupture and hysterectomies, hemorrhagic shock and suppurative septic complications. Another important observation was decrease of childbirth trauma. Thanks to rights and choice-based approaches health professionals noted positive mood of pregnant women during delivery and decrease of postnatal depression due to rights and choice based approach. Considering cost effectiveness, efficiency and relevance of EPC programme and standards to country context, it needs to be expanded in rural and district maternity houses.

Some of the visited clinics reported that they had no cases of maternal mortality thanks to implementation of EPC and BTN. Stakeholders at both the national and regional level provided evidence for significant improvements in emergency obstetric care that are strongly contributed to reduce the risk of maternal death and morbidity which is directly linked to UNFPA supported activities.

UNFPA provided technical support to the Republican Medical College for the revision and updating the basic midwifery training program. The updated curriculum meets the requirement of International Confederation of Midwives. For more than 17 years midwives were trained as nurses at the first three years of basic education and only fourth year was devoted to learning midwifery programme. Hence, most challenges in terms of theoretical and practical skills of midwives came from these missed opportunities. Thanks to UNFPA imitative and support colleges have started introducing the new updated curricula for basic education of midwives in 2018 teaching them from the beginning as midwives but not nurses. Tutors of medical colleges are trained within updated midwifery programme. Along with this UNFPA supported Republican and regional medical colleges with the establishment of a training center for Virtual Interactive Contraception training package.

Assessment of implementation of pilot cervical cancer prevention project funded by HelloSmile has demonstrated the following: 1) A pilot model of organized cervical cancer screening and pre-cancer treatment was introduced for the first time in the country achieving over 93% of coverage of the target population. 2) New recording/reporting system based on the “Comprehensive Cervical Cancer Control” guide of WHO and including other SRH related indicators was introduced. This new form allowed collecting information on various conditions related to SRH from women who received CCP screening. 3) A clear and targeted information campaigns facilitated dialogue and raised public awareness and their participation at the early detection of cervical precancerous diseases and other RH issues. 4) Coordinated multi-sectoral cooperation for improving women’s sexual and reproductive health created a platform for further collaboration of local government authorities to address other public health issues in Khatlon and Sugdh provinces.

The pilot project also made achievements beyond the initial project objectives: a number of other Reproductive health issues (contraception, myoma, extragenital diseases, etc.) were identified and addressed; capacity building activities contributed to improvement of overall SRH services that meet internationally agreed evidence-based standards and significantly contributed to the institutionalization and sustainability of the SRH programme.

In order to improve the accessibility of family planning methods and increase capacities of institutions to deliver integrated sexual and reproductive health services, a series of trainings on FP, long & permanent methods like IUD insertion including in post-partum period and rights-based voluntary surgical sterilization were conducted. Mostly trainings were organized for midwives from selected rural villages. Each midwife who received the certificate was equipped with a kit for inserting and removing IUDs. Each trained midwife in average inserted 80 IUDs. Post-partum FP trainings were targeted at the midwives of maternity houses who are in charge of counselling and service provision on FP. Huge efforts were also made to ensure that teachers of Republican and Regional Family Medicine centers are re-trained on family planning counselling and teaching techniques.

In parallel, UNFPA technical support to MoHSP was provided for development of Clinical Protocols on voluntary surgical sterilization and modern methods of contraception based on the updated WHO Global Handbook on Family Planning. It worth mentioning that all capacity-building interventions are based on the family planning situation analysis conducted jointly by the team of MoHSP and International Expert.

The implementation of the CHANNEL Logistics Management Information System software system and continuous capacity building is major accomplishment. Based on site visits and stakeholder interviews, it was clear that the system is being used effectively to monitor the stocks of contraceptives according to type and expiration status. All Reproductive Health Centers specialists had a knowledge of the current status of every method. The system permits regions to identify locations where there are possible stock outs and where there is excess supply that can be shared with locations that lack supplies.

Due to UNFPA advocacy in 2016 MoHSP established a dedicated Thematic WG on SRH in Crisis. UNFPA in collaboration with the members of the Thematic SRH WG in crisis were able to: 1) Develop and approve National and 3 Regional Action Plans on SRH in emergencies; 2) Roll-out Minimum Initial Service Package for SRH in Crisis including ASRH needs nationwide covering 160 RH staff 3) Develop and introduce SOPs and Clinical protocol on provision of health care services to the victims of GBV 4) Ensure that SRH and Gender aspects are integrated at the Inter-agency contingency plan of UN agencies and National DRR Strategy till 2030; 5) Assisted MoHSP to stockpile dignity kits to respond to emergency situations.

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
A2.2. CP has achieved intended outputs and outcomes in the Adolescents & Youth focus area	<ul style="list-style-type: none"> Evidence of achievement of intended outputs Evidence of achievement of intended outcomes 	<ul style="list-style-type: none"> CPD AWPs, SPRs, COARs Monitoring reports Policy documents and methodological materials developed with UNFPA support 	<p>Document review</p> <p>Interviews with:</p> <ul style="list-style-type: none"> UNFPA CO staff Implementing and national partners CP Beneficiaries <p>Focus groups with CP beneficiaries</p>

The CP has reached all targets for its outputs and outcomes in the Adolescents and Youth focus area.

Output 1: Increased capacity of national institutions and networks to conduct evidence based advocacy for incorporating adolescents and youth rights in national laws, policies and programmes.

Indicator	Baseline	Target	Actual
Number of UNFPA supported youth platforms that advocate for increased investments in youth and adolescents, including marginalized youth, within development policies and programmes	1	6	5
Number of civil society networks supported by UNFPA that engage in programmes addressing sexual and reproductive health needs of marginalized and vulnerable groups, people living with HIV and key populations	4	10	19

Output 2: Increased participation of civil society organizations in promoting sexual and reproductive health and rights of vulnerable and marginalized youth groups.

Indicator	Baseline	Target	Actual
Number of civil society interventions completed with UNFPA support that address adolescent girls at risk of early marriage and harmful practices.	0	8	6
Proportion of secondary high schools that have adopted healthy lifestyle education, following international standards for grades 10 and 11	0	10% (320 schools)	On track: 260 schools 81% of target (as of 2019)

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

Indicator	Baseline	Target	Actual
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Number of new policies and programmes in place addressing sexual and reproductive health needs of youth and adolescents, including marginalized youth.	0	3	3
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Supported youth organizations and platforms increased their technical expertise in delivering services as well as general organizational development, including overall management, monitoring and reporting, strategic partnership building with national state institutions and other relevant INGOs for furthering youth and adolescent agenda. National Y-PEER Network (Hamsol ba Hamsol) has been capacitated to promoting community-based peer education and healthy lifestyle education within secondary school in cooperation with Academy of Education, Ministry of Education and Teachers` Training Institute.

HLS course

Focus group discussions conducted with teachers who participated in the ToTs and currently teach HLS in pilot secondary schools demonstrated high level of willingness and overall adequate capacity to deliver the HLS courses. Teachers in majority of schools have shared the materials and information with their peers thus transferring the knowledge further and building the institutional memory within their respective schools. However, it should be noted that teachers expressed certain challenges with delivering information on specific sensitive (condom use, STI, sexual relations, sexuality, etc) topics within SRH, where according to them health professionals would be better fit to respond to the needs of the students. Discussions with secondary school children demonstrated that HLS courses have been warmly welcomed by adolescents in relevant schools and they have genuine interest in the topics. Students express interest in the courses, share positive feedback and can elaborate on SRH topics.

UNFPA is the only actor in promoting HLS at secondary school level in the country for the time being and thus partnership with Ministry of Education considered as strategic towards institutionalization of HLS. Having said that, in 2019 UNFPA signed IP agreement with MoE to increase ownership for HLS and thus ensure sustainability of HLS activities.

In 2017, the MoHSP has established 21 medical-consultancy cabinets (centers) for youth (MCCY) in 12 districts within five regions. UNFPA contributed with strengthening capacity of MCCYs responsible staff and provided them with adapted WHO OP manual. During FGDs with students of secondary schools undergoing HLS courses and teachers delivering HLS courses, majority of the participants did not possess any information about the existing MCCY within their districts and the type of services they provide. (can we indicate the reason, e.g. location of YFC, proximity to school, etc). More meaningful integration of MCCY staff in the HLS education would strengthen the impact and positively contribute to the work of HLS teachers.

Sexual and reproductive health and rights of vulnerable and marginalized youth groups

UNFPA CO provided support to civil society organizations in promoting sexual and reproductive health and rights of vulnerable and marginalized youth groups. During 2016, UNFPA CO was engaged with strengthening capacity of 19 CSOs working on prevention of promotion of sexual health and rights of SW and MSM. Specifically, these services included functioning services of Trust Points, counseling and HIV/STI testing services, distribution of commodities (condoms, IEC, counseling and referral) to MSM and SW groups, advocacy and community mobilization, building leadership and self-worth of key population. Interviews conducted with some of the CSOs demonstrate in-depth understanding of specific vulnerabilities and needs of MSM and SW among staff contributing to the effectiveness of their work with key population. Even though UNFPA has not been engaged with the same project through collaboration of 19 CSOs beyond 2018

and UNDP has taken over the initiative, these CSOs still have trusted relationships and engagement with SW and MSM groups they have worked with previously. MSM and SW expressed appreciation and satisfaction with the services they were receiving in 2016 and emphasizing importance of the approach UNFPA was taking in engagement with key population. Specifically, they mentioned that services were provided in a respectful and sensitive way, outreach work was effective and contributed to coverage of large number of key populations, services were not simply limited to commodities distribution but more holistic, rights-based approach. *“UNFPA approach to provision of services for MSM was more comprehensive, we had site visits among outreach workers from MSM, certain activities contributing to psychological coping with our specific challenges. I experienced self-stigmatization and stigmatization from others. After cooperation with UNFPA as an outreach worker, I gained more self-respect”* (MSM Focus group respondent).

In parallel with engaging CSOs, UNFPA has been promoting sexual and reproductive health and rights of vulnerable and marginalized youth groups through collaboration with state institutions. In 2016 UNFPA CO signed a partnership agreement with Republican AIDS Center to increase ownership for HIV response. Jointly with AIDS Center UNFPA CO facilitated an initiative to establish a Technical Working Group (TWG) on integration of SRH/HIV/STI services for key populations at PHCL. In 2017 UNFPA CO documented the Trust Point (TP) model to ensure comprehensive integrated SRH services; improving the integrated services for key pop at primary health care level. Focus group discussion with MSM group at the premises of one of the Trust Points which operated until 2017 showed considerable difference in provision of services to key population in a non-discriminatory and sensitive way. Focus group participants among MSM highly appreciated the professional attitude of the staff of Trust Points, and the evaluation team also observed that FGD participants among MSM unlike in other places were feeling safe and secure at the premises. In the absence of adequate services, currently key population refer to trusted doctors, who have made good partnership and sustain relationships with UNFPA NGO partners from 2016. However, based on other FGDs not all Trust Points and integrated services have the same level of sensitivity and professionalism in working with key population. In order to further enable integration of SRH/HIV/STI services to meet the specific needs of key population, UNFPA in partnership with IP among CSOs organized a technical visit for HIV/STI/RH centers deputy directors to Trust Points operating under different modes and an integration roadmap was developed and submitted to MoHSP. UNFPA partners among CSOs have been promoting the issue further through advocacy, round table discussions and other venues.

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
A2.3. CP has achieved intended outputs and outcomes in the Gender focus area	<ul style="list-style-type: none"> • Evidence of achievement of intended outputs • Evidence of achievement of intended outcomes 	<ul style="list-style-type: none"> • CPD • AWP, SPRs, COARs • Monitoring reports • Policy documents and methodological materials developed with UNFPA support 	Document review Interviews with: <ul style="list-style-type: none"> • UNFPA CO staff • Implementing and national partners • CP Beneficiaries (including clients of VSRs)

The CP has reached all targets for its outputs and outcomes in the Gender equality focus area.

Output: Strengthened capacity of institutions to enable delivery of multisectoral services and to address gender based violence and discrimination in line with international human rights treaties obligations.

Indicator	Baseline	Target	Actual
Number of analytical studies to establish evidence on effects of gender inequality and gender-based violence conducted to guide policy	1	3	3
Number of new policies addressing gender inequality, gender based violence and gender biased sex selection developed	1	3	3
Number of public campaigns addressing gender equality, non discrimination and gender based violence and gender biased sex selection, including through engagement of men and boys	10	15	27

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

Indicator	Baseline	Target	Actual
Proportion of CEDAW concluding observations on sexual and reproductive health and gender based violence from previous reporting cycle implemented or action taken	To be set	50%	50%

UNFPA supported a number of **studies and surveys on gender inequalities** in line with SDG indicators. The findings of these surveys are incorporated into programme planning, CEDAW reporting and revision of policy frameworks on gender. It was found out that district women committee authorities are not well informed on international treaties and CEDAW recommendations. Thus, CP in the frame of RRF supported the CoWFA with localization of CEDAW national plan of action at the district levels of Khatlon and Sughd provinces. CPE team noted that most development processes in all spheres (economic, social) are undertaken in the capital and regional centers and rural areas are less benefitted from these processes. It is also documented in the National Reporting on SDG implementation (2018).

Institutionalization of VSRs located within maternity houses have significantly contributed to the effectiveness of the service provision to victims of **gender-based violence** (GBV) among women and girls. In the period of 2013-2019 (7 month) – VSRs provided gender sensitive services to almost 860 victims of GBV and sexual violence. Visit of the evaluation team to three VSRs in Khatlon and Sughd provinces validated the statements of other local actors involved in the referral system of GBV victims, specifically victims of domestic violence (DV) on effectiveness and crucial role of VSRs as response mechanism. The location of the facilities within maternal houses, interior arrangement of the rooms and increased gender sensitivity of the responsible focal points positively contribute to the help-seeking behavior of potential GBV victims with significant number of women referring to the VSRs for help. Women of different ages and experiences of DV have been referring to victims` support rooms for help, including older women, adolescent girls, women with children who have an opportunity to be sheltered together with their minor children. *“I have been here for three days now; I feel much better. I needed a place with some privacy to think and digest what happened to me. None of my relatives except niece knows where I am. Staff of this facility supported me and provided me with medicine and meal”*. It should be noted that staff of VSRs

have been handling cases with different forms of GBV, including highly sensitive cases such as marital rape and teen pregnancies in a delicate and effective way. The adopted regulation of MoHSP on the operation of the VSRs specifying the types of services available in the premises and specification of domestic violence as a specific form of GBV that VSRs are mandated to respond and help enhancing the quality of the services. During the interviews, staff of VSRs were able to elaborate on their functions and approaches applicable in responding to GBV cases. Registration and handling of client`s information within VSRs needs further improvement. The responsible personnel at VSRs register incoming clients in a unified manner according to the registration card endorsed by the MoHSP but it differed by VSRs, in some cases the data is inconsistent and not comparable across different locations. The responsible staff of VSRs have established strong partnerships locally with existing services for victims of gender-based violence i.e. psychological and legal support within the local branches of Committee on Women and Family Affairs, NGO-run crisis/resource centers for women funded through other international donors and existing gender sensitive police units where inspectors on response to domestic violence are available. Given the strong and long presence of NGO-run services for victims of DV and other forms of GBV in the country, it is rational to increase inclusion of NGOs in the UNFPA activities on strengthening multi-sectoral response to gender-based violence along with relevant state institutions.

CO in cooperation with UNFPA Regional Office and Eastern Europe Institute on RH supported introduction of Standard Operation Procedures (SOPs) for health, police and psychosocial services in Tajikistan. Multi-sectoral cooperation platform to response to GBV is established within current CP consisting of Ministry of health and social protection, Committee of women and family affairs and Ministry of internal affairs. SOPs are introduced to MSCR team. Recently the MoHSP have adopted SOP for health in state language and it needs to be integrated into health education and services.

MSCR team conducted regular monitoring, exchange visits to VSRs, and conducted advocacy meetings based on findings and outcomes of visits. This activity forced MSRT to find out missed opportunities within the Law on prevention of violence in the family and initiate revision process. The Government of Tajikistan created three technical groups for revision of current Law including one in CoWFA, second in General Prosecutor Office and third in Ministry of justice (this is ongoing).

UNFPA organized cross visits for multisectoral actors working on GBV prevention and response has positively contributed to strengthening GBV referral network. Staff of VSRs in respective locations, relevant staff of CoWFA and police all mentioned the cross visits and monitoring as a strong channel which provided an opportunity for them not only to learn from the work of specialists in other locations, but better organize the referral within their district and locations once they were introduced to each other and immersed in a joint learning experience. This approach strongly contributed to creating multi-sectoral cooperation response team at those levels where VSRs are functioning.

The “Guidance on strengthening of health sector response to gender-based violence” and SOPs for health professional adopted by MoHSP, promoted by UNFPA, are essential tools for enhancing SRH service provision to victims of GBV. Availability of these guidelines and SOPs are critical for strengthening the referral system as well. During interviews staff RH centers were giving information on attended trainings and other UNFPA capacity building activities on engagement with gender and GBV work. However, recently adapted SOP for health need to be introduced to RH centers at different levels.

UNFPA was the first organization to introduce an effective innovative approaches such as **Public Health Fairs** in the country – qualified specialists and professors from capital and regional centers came to remote villages and provide gender sensitive, quality health and legal services to the population of remote rural areas including providing services to furthest behind – migrants’ wives and daughters, people with disabilities, young mothers and poor population who was not able to

reach these services by qualified experts. Notable remark CPE team made is that young girls and mother in laws were also visiting these PHFs. This helped experts to advocate and increase their awareness on prevention of early and forced marriages, complications of early pregnancies, following inter-birth interval, promoting rights of young girls and mothers to education, prevention of cervical cancer etc. One of visited Rural health center staff mentioned that: *“When we informed our population about a visit of qualified experts from capital to this rural health center, they were very happy as most of them are from poor families, their husbands, sons are in labor migration and they cannot allow them to go to regional center or capital for qualified services. During this health fair all population of our territory came to use services of qualified specialists. This was very effective considering population perception and bringing services close to the population. We have a growing number of divorces among young couples. Experts worked with mothers and mothers in law on prevention of early marriages and divorces that are directly linked to GBV in the family”*. Within each of public health fairs, more than 500-600 women and girls received counseling, health and legal services.

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
A2.4. CP has achieved intended outputs and outcomes in the Population and Development focus area	<ul style="list-style-type: none"> • Evidence of achievement of intended outputs • Evidence of achievement of intended outcomes 	<ul style="list-style-type: none"> • CPD • AWP, SPRs, COARs • Monitoring reports • Policy documents and methodological materials developed with UNFPA support 	Document review Interviews with: <ul style="list-style-type: none"> • UNFPA CO staff • Implementing and national partners

In 2016-2019 the CP has already achieved most of the planned outputs and outcomes (as defined by target values of indicators) in the area of Population and Development.

- **The CP made significant contribution towards building national capacity necessary to conduct population and housing census 2020. One of corresponding output indicators (number of trained national specialists) has been already achieved in 2016-2019, output indicator related to successful conduction of the 2020 census is likely to be achieved.**

In 2016 the CP supported development of the 2020 census action plan that includes related budgets, procurement plans, dissemination, pilot census and training needs. In 2016-2018 CP supported a number of training events for the Statistic Agency specialists who will be involved in conducting the census, including seminars on the use of modern technology and a study tour to Belarus and Russia.

Interviewed specialists of the Statistics Agency who participated in the training events organized by the CP reported that they got new knowledge and skills, especially related to the use of tablets and internet. According to respondent these skills were successfully applied during the pilot census conducted in October 2018 in Nurek, Khatlon region, and two micro-districts of the city of Dushanbe.

Specialists trained by the CP shared the new knowledge with colleagues thus increasing the reach of the UNFPA capacity building efforts, though these training events were reportedly less effective because people based outside of regional and district centers were not financially supported to attend and did not participate full time.

The actual number of national specialists trained through UNFPA support in the production, analysis and dissemination of census surveys and other statistical data in 2016-2019 is 590 which already exceeds the CP target of 500. Successful implementation of the pilot census in 2018 suggests that 2020 population and housing census in 2020 will be conducted and the corresponding CP output indicator will be achieved.

- **In 2016-2019 the CP has already achieved the target for the number of new conducted population surveys. UNFPA support was instrumental both in terms of building capacity of the staff of the Statistics Agency to conduct those surveys and technical and financial support to survey implementation.**

In 2016, UNFPA supported conducting of the resource flow survey on the national expenditure on family planning. Survey results were incorporated in global report on Family Planning Resources Flows (COAR 2016). CP also supported training for 16 Statistics Agency specialists from provincial branch offices on how to conduct thematic surveys.

In 2016-2017 as part of the Labor Force Survey UNFPA supported the survey on migration issues – in partnership with the Statistic Agency and the World Bank. UNFPA supported the development of the migration module as well as data collection, analysis and preparation of report.

In 2017 UNFPA supported implementation of the DHS survey.

In 2018 within the framework of the CRVS project quantitative and qualitative survey on “Assessment level of population awareness and usage of Civil Registration services in Tajikistan” was conducted among the target population in 4 project districts. The survey helped to identify the most effective strategies for raising awareness and promoting the use of civil registration by the population.

- **The CP contributed towards establishment of the tracking and reporting system to monitor implementation of national plans and policies in the areas of demography, sexual and reproductive health, youth, gender equality and humanitarian response.**

In 2016 UNFPA – in cooperation with UNICEF - supported upgrade of the TojikInfo online database that allows users to review and analyze poverty levels and social status of population, demographic trends, population health status and social inequality spatial trends (COAR 2016).

- **The CP contributed towards greater capacity of national and regional authorities, including members of parliament, to use demographic data for development of national and regional development programmes.**

In 2016 UNFPA supported the development and delivery of trainings based on the “Population Handbook” that reached 34 regional specialists responsible for regional development programs. In 2016 UNFPA supported members of the Population and Development Committee under the Parliament of Tajikistan by making a presentation on the main population and development concepts and on emerging population issues. In 2017 UNFPA supported a member of Tajikistan Parliament to attend the demographic courses hosted by HSE in St. Petersburg, Russia.

- **The CP has already achieved its target for a number of new development policies and strategies that address population dynamics** (Baseline: 1; Target: 3).

In 2016 UNFPA contributed to the development of the National Development Strategy for 2016-2030 and the national mid-term development strategy for 2016-2020 by providing recommendation on population issues.

In addition, through the CRVS project UNFPA contributed towards improvement of the national CRVS system through improved regulation and technical capacity as well as provided direct support with obtaining necessary CRVS certificates to people in remote villages.

UNFPA contribution to implementation of the CRVS project included:

- Sensitization of the national authorities (members of Parliament, staff of the Ministry of Justice and other relevant state agencies) about importance of improvement of the CRVS system;
- Piloted the system for digital transfer of CRVS records in Kulyab region;
- Over 4,000 people in three pilot districts were reached by face to face information campaigns and mobile consultations;
- Over 150 children (1-16 years old) received a birth certificates due to support provided in the course of mobile consultations.

EQ4. To what extent has UNFPA policy advocacy and capacity building support helped to ensure that sexual and reproductive health (including Family Planning), and the associated concerns for the needs of young people, gender equality, and relevant population dynamics are appropriately integrated into national development instruments and sector policy frameworks in the programme country?			
Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
A4. New development policies and strategies developed with UNFPA support include explicit reference to SRH, needs of young people, and gender issues	<ul style="list-style-type: none"> • Evidence of reference to SRH, needs of young people and gender issues in national development instruments and sector policy frameworks 	<ul style="list-style-type: none"> • Policies and programme developed with UNFPA support 	<p>Document review</p> <p>Interviews with national partners involved in the development of these documents</p>

UNFPA supported the development of a number of important policy documents in the SRH area.

From 2015 to 2018, UNFPA supported several in-depth studies and evaluations related to reproductive health: survey on quality of integrated SRH in PHC, assessment of RH/FP in Tajikistan, needs assessment and review on Cervical Cancer prevention, review of Midwifery programme, assessment of quality of care at the hospital sector. These assessments led directly to the development of interventions and protocols for addressing key reproductive health concerns to achieve results. For example the Sexual and Reproductive Health Services Quality assessment (2016) led to the development, approval and introduction of two strategic documents “Strategic plan for the development of family medicine-based primary health care in the Republic of Tajikistan, 2016–2020” and “National Plan of Actions on Reproductive, Maternal, Neonatal, Child and Adolescence Health for the period of 2016-2020”. Based on results of Needs assessment on cervical cancer prevention, the project proposal is developed and funding support received from Japanese HelloSmile Project. Post project implementation review is conducted for analysis of effectiveness of this project and delivering recommendations to the MoHSP on further step. These sequential integrated approaches helped CP to go beyond initial targets and contributed to formulation of SRH policy.

UNFPA contributed towards development of important policy frameworks in the SRH area:

- National action plan on Reproductive health, maternal, newborn, child and adolescence health (2016)
- Health code of Tajikistan (2017)
- Strategic plan for the development of family medicine-based primary health care in the Republic of Tajikistan (2016–2020)
- National Program on SRH for (2019-2022)
- National Communication Strategy on SRH
- National HIV Prevention programme 2018-2020
- National Development Strategy-2030, item: (2) health care.

UNFPA supported the development of a number of important regulations and guides in the Adolescent and Youth area.

UNFPA CO advocacy efforts facilitated the adoption of the Decree of the Ministry of Education of the Republic of Tajikistan issued in April, 2017, according to which the national work group (WG) was established to develop the curriculum for teachers and the textbooks for the school children of 10-11 grades on Healthy Life Style Education. The Academy of Education and Teachers` Training Institute developed HLS modules for grades 10-11 of secondary school students and tested these modules with teachers to contextualize them. Further in 2018, UNFPA initiated a signature of a partnership agreement with the Ministry of Education to institutionalize the HLS subject. UNFPA IP, YPEER has signed Memorandum of Cooperation with Ministry of Education for five years to promote the concerns and needs of young people.

In 2016 UNFPA CO provided technical support to the MoHSP with revision of existed normative documents in the area of adolescence and youth health. In order to increase access of marginalized group to SRH services, amendments were made to the Law on Reproductive Health and Reproductive Rights and follow up regulation document “The procedure for providing health services and consultations on reproductive health to adolescence and young people, including representatives of the key pop” was developed and approved by the government.

Such guidelines SWIT, YKP tool kits focusing on the specific needs of key population and providing relevant tools for organizations and agencies responding to these needs has been adopted and approved. The guideline has been examined by the Ministry of Health and endorsed for use by relevant institutions and organizations working with key population.

UNFPA supported development and adoption of a set of SOPs that regulate comprehensive multi-sectoral response to GBV.

UNFPA initiative on strengthening multi-sectoral response to GBV in a consistent manner is very critical given the weak state of coordination between different GBV responders and sporadic initiatives on enhancing collaboration. The multi-sectoral response is a core element in operationalizing domestic violence prevention law. This work has helped to bring relevant actors together in a meaningful and organized manner to increase their coordination when dealing with cases of GBV as well as providing space for advocacy and development of other specific policy instruments. The recommendations of multi-sectoral working group served as a basis for the government to create three working groups on revision of the Prevention of Domestic Violence law. Development and endorsement of SOPs for health sector professionals is a major step in enhancing the quality of services and strengthening the referral system. Promotion and drafting of SOPs for law enforcement and social workers is another important step in gradually achieving the goal on creating effective sectoral response mechanism. Youth friendly centers face challenges with law enforcement structures when dealing with teen pregnancies or cases of GBV involving adolescents. The country's laws and regulations require staff of YFCs to report these types of cases to law enforcement and breach the confidentiality principle. Law enforcement needs to be trained on handling these types of cases with increased sensitivity. The concerns and needs of adolescent girls among GBV victims or cases of teen pregnancies should be explicitly covered in the SOPs on responding to GBV for law enforcement that are in the process of enrichment and adoption.

Mainstreaming gender sensitive approach in humanitarian and emergency context has been done through adaptation of SOPs for Prevention and Response to Gender-Based Violence in Emergencies based on reached agreement between UNFPA and MoHSP in 2016. The Thematic SRH WG in crisis established under the decree of MoHSP in 2016 developed the Clinical Protocols for Rape Survivors as part of the Minimum Standards for Prevention of GBV in emergencies within the Minimum Initial Service Package for SRH in Crisis being rolled-out nationwide.

UNFPA supported integration of issues of population dynamics into national policy instruments.

UNFPA supported a series of training activities to build capacity of national stakeholders to use population data for policy development. Due to improved capacity building among civil servants of government institutions following Strategies, Law, Concept, Program were designed:

- **National Development Strategy for 2016- 2030** which is the main focus of SDGs is the concept of Sustainable human development. Therefore, complete eradication of poverty, replacement of unsustainable and promotion of sustainable consumption and production patterns, as well as protection and sustainable use of natural resources to ensure further economic and social development are the main objectives and key factors of sustainable human development. (NDS 2030).
- **Medium-term Development Program for 2016- 2020** where mentioned that government activities of country present time and future would be directed for achieving strategic aims: 1) Ensuring energetic safety and effective use of electricity; 2) Exiting from communication deadlock and converting country for transit; 3) Ensuring food safety and access population for qualitative nutrition; 4) Broadening productive employment. Without realization these aims, to achieve SDG

(Sustainable Development Goals) approved in 70- session of General Assemble of UN in 2015 it is impossible. There are 6 key problems concerning population dynamic like improving demographic data, capacity building, increasing awareness of population concerning family planning and others finding their solution.

- **State Youth Policy Strategy in the Republic of Tajikistan till 2020**
- **Law concerning “Compulsory medical examination for youth before marriage” (for the purpose of detection of possibility to be pregnant and AIDS**
- **Concept of family development (2016).**
- **2017 Demographic and Health (DHS) Survey: UNFPA provided technical support to the second DHS Survey in Tajikistan, undertaken in collaboration with the Statistical Agency.**
- **State Programme on RH for 2019-2022:** This program is developed to promote family planning, increase accessibility, quality and efficacy of reproductive health services for population, primarily focusing on youth. The Programme intends to improve women’s health, educate in sexual ethics, involve the Development partners, civil associations and private sector to ensure funding of educational institutions, healthcare facilities with modern equipment and technologies and contraceptives are equipped. It also intends to train health workers in reproductive health, strengthen contraceptives supply and distribution management, develop information and education materials, raise population awareness and knowledge in the reproductive health issues.

EQ5.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 country programme?			
Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
A5. UNFPA CO made good use of its human, financial and technical resources	<ul style="list-style-type: none"> ● Number of interventions managed by individual managers ● Degree of use of allocated funds ● Degree of implementation of AWP ● Evidence of synergies between components ● Evidence of synergies with other organizations doing similar projects ● Perception of national partners 	<ul style="list-style-type: none"> ● CPD ● AWP, SPR, COAR ● Monitoring reports ● Financial reports 	<p>Document review</p> <p>Interviews with:</p> <ul style="list-style-type: none"> ● UNFPA CO staff ● Implementing partners ● National stakeholders

CO realignment

In 2016-2018 CO went through the realignment process. The new organigram retained AR (NOC), Programme Analyst (PA) on SRH&Gender (NOB), PA on Population and Development (NOB), AdminFinance Associate (AFA/G7) and Drivers (G2&SB2) from the previous cycle. The following new posts were established

and filled with the staff: PA on HIV&Youth (NOA), Programme Associate on SRH (G7), Programme Associate on Communication and Advocacy (CA), Programme assistant (G5), Administrative Assistant (G5). In addition, within donor funds CO recruited Project AFA under SC (SB3).

During the CP implementation period due to career promotion of CO staff to international positions and leaving to other organizations, CO staff have undertaken backstopping functions in addition to their JD to support smooth implementation of CPD delivery. For instance, Programme AdminFin Assistant performed AFA tasks (2016-2017), SRH NPO performed PD NPO (2016) work, HIV NPO performed adolescents (2017-2018) and PD NPO (2017)'s work, Programme Associate on FP/RHCS performed Procurement focal point for RH commodities (UNFPA Supplies) and CP Humanitarian response FP (2016-2019). In the absence of PA on PD (detail assignment in Asia and the Pacific Regional office, duration - September-December 2019), Programme assistant is backstopping this position. Administrative Assistant is performing Programme Associate on CA since September 2019 till present (vacant position, recruitment process is initiated). Since, November'2018 till now, PA on SRH&Gender is performing the duties of acting AR position.

The office was undergoing re-transformation of personnel and staff turnover to international positions and other agencies, however, the office made every effort to cope with the shortage of staff using the mechanisms of redistribution of workload in agreement with the staff. This demonstrated staff's commitment and loyalty to the aims, principles and purposes of the UNFPA and passion for their work. Strong teamwork and cohesion allowed the office to achieve all CPD targets and demonstrated tangible results.

Close cooperation with government partners and integration with existing national systems and processes facilitate high efficiency of the use of UNFPA financial resources. National partners interviewed by the evaluation team noted that UNFPA is making good use of its financial and human resources^ *“UNFPA does not have much money. Nevertheless, with these modest funds they achieve many results due to close cooperation with national counterparts. They show us the modest and effective ways in addressing our challenges and needs. They work continuously until achieving results in spite of challenges and barriers they met”.*

EQ6 To what extent have the partnerships established with ministries, agencies and other representatives of the partner government allowed the country office to make use of the comparative strengths of UNFPA, while, at the same time, safeguarding and promoting the national ownership of supported interventions, programmes and policies?			
Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
A6. UNFPA was successful in influencing government institutions to adopt approaches promoted by UNFPA	<ul style="list-style-type: none"> Evidence of recognition of UNFPA comparative strengths by government partners Evidence that UNFPA was able to advance its agenda and strategic vision to the government (advocacy) 	<ul style="list-style-type: none"> CPD AWPs, SPRs, COARs Monitoring reports 	Document review Interviews with: <ul style="list-style-type: none"> UNFPA CO staff Implementing partners National partners

According to UNCT members interviewed by the evaluation team one of the strengths of the UNFPA CO is its ability to maintain a **balance between pursuing its mandate and ensuring national ownership** of its work.

The evaluation has found that UNFPA is consistently using approaches that promote national ownership of supported interventions including: (i) regular consultations with stakeholders; (ii) building on national systems and processes, (iii) supporting dialogue between national stakeholders; and (iv) national execution of supported interventions.

- **Regular consultations with stakeholders**

The evaluation has found that Tajikistan authorities demonstrate a high level of commitment to the national development agenda, especially in the health sector. For example, the national parliament closely oversees the implementation of the National Health Strategy 2010-2020, especially situation with MMR and child mortality. The MoHSP has established the Development Partner Council to coordinate donor efforts. The Council meets on a monthly basis to discuss the progress of the projects and intervention supported by the partners. Sites to be targeted by donor interventions are usually determined based on the administrative statistics collected by the MoHSP. In addition, UNFPA holds annual review and planning meeting with the national stakeholders.

The evaluation data indicates that UNFPA being open to ideas emerging from consultation with national partners contributes towards greater ownership of planned interventions. For example, in 2016 national partners discussed possible UNFPA support to improvement of the SRH services provided by the primary level health institution in line with the *National Health Strategy 2010-2020* and *Plan for the development of primary medical and social services using family medicine model 2016-2020*. The Republican Training and Family Medicine Center suggested to start with doing the assessment of the quality of SRH/FP/MH/GE services provided by the primary health care centers conducted by the Republican Training and Family Medicine Center. UNFPA supported the initiative and survey is conducted by the staff of this Institute in 2016. Data collection instruments were based on WHO assessment tool. Assessment covered provision of family planning services, antenatal care, services to adolescent, prevention of STIs and HIV, prevention of cervical cancer, prevention of GBV. Results and recommendations of this assessment were presented to the MoHSP and development partners leading to the development of the national action plan. Based on findings of this assessment the MoHSP and UNFPA addressed the existing challenges during planning for 2017-2019 toward achieving CP RRF.

Within the framework of the intervention that aimed to promote integration of service for key populations (SWs and MSMs) from NGO to government health sector stakeholder consultations were used to develop a road map for the integration process. Intervention included delivery of three advocacy and service integration workshop for NGOs working with key populations and three workshops for family doctors on service provision to key population. UNFPA and an implementing partner allocated part of the time during these workshops for consultations with stakeholders to get their ideas and recommendations that formed the basis for the forthcoming road map. The draft of the road map was submitted to the MoHSP for further consultations.

All training materials developed with UNFPA support become effective only after approval by the relevant national stakeholders.

- **Building on national systems and processes**

Majority of UNFPA capacity building interventions target already existing national institutions and systems: primary health care system, reproductive health care system, maternity clinics, the system of Training and Family Medicine Centers, midwifery education system, school system, civic registry system and the national statistics system. UNFPA also supported building of institutional capacity of already existing national NGOs and supported their networking.

Even when UNFPA was supporting the newly established structures, these structures were usually established on the bases of already existing institution. For example, in 2018 the Ministry of Justice established a working group responsible for development of the CRVS-related communication strategy. (The group was institutionalized by the decree #99 from July 18, 2018.) UNFPA supported operation of this group within the framework of the CRVS project by providing results of an assessment of the capacity the Ministry of Justice to disseminate civil registration information among population and training “Communication Strategy and Work plan to increase legal education of population on timely civil registration acts” for group members.

- **Promoting dialogue between national stakeholders**

UNFPA is consistently supporting round tables and cross visits to promote dialogue and exchange of experience between national stakeholders. In many cases, these activities are seamlessly integrated in UNFPA support targeting some specific issue.

UNFPA CO supported regional advocacy meetings on ICPD and SDGs promoting reduction of maternal mortality and reducing unmet needs for family planning involving 280 health managers from 72 districts of Sogd and Khatlon provinces, which led to increase of commitment of local managers to SRH, MH, FP and HIV prevention.

Meetings have already led to greater awareness among health managers about importance of SRH, FP, MH and HIV testing among pregnant women to prevent mother to child transmission and their commitment to ensure availability of testing. In the past UNFPA supported the national partners with provision of HIV rapid tests for pregnant women from UNFPA Supply Funds as a temporary assistance. However, thanks to UNFPA evidence based advocacy the MoHSP started allocation of some funds to cover this need. State funding is not sufficient to ensure uninterrupted supply of HIV express tests to health facilities. To resolve this problem district managers have started doing their own fundraising from local state funds to purchase HIV express tests and ensure consistent access to HIV testing of pregnant women in their districts.

To achieve universal access to quality FP information and services, UNFPA and the Ministry of Health and Social Protection (MoHSP) of Tajikistan agreed to develop and implement interlinked strategic course of action. The immediate need was to close the financing gap of contraceptive supply to ensure availability of a range of FP methods but it was felt that it was also important to make the National FP programme stronger in order to close the unmet needs. To achieve both strategic objectives, advocacy interventions were made together with the National Committee on Population and Development made up of the Parliamentarians, key Government ministries and the media to the Government of Tajikistan (GoT) to create a budget line and start allocating the state budget for contraceptive procurement and to develop a new State Programme to strengthen FP programme being an integral part of the comprehensive National Action Plan on Reproductive, Maternal, Newborn, Children and Adolescence Health 2016-2020.

Another example, in 2017 UNFPA supported assessment of the accessibility and quality of SRH services provided to SWs and MSMs by primary health level institutions. Assessment was conducted by the Republican Training and Family Medicine Center. UNFPA CO and NGOs working with these groups helped with the development of the questionnaire that was used to collect information from the staff of the primary level health institutions. Assessment revealed that medical staff

was poorly informed about HIV transmission paths, stigmatized SWs and MSMs, and had poor skills in the area of pre-test counseling and overall work with key populations.

During the field visit to the city of Khujand, Sugdh province, the evaluation team was able to observe the round table organized with the CO support. The round table brought together state HIV centers and NGOs providing services to key populations (SWs and MSMs) and provided them a venue for discussion of existing challenges and possible solutions. One of the themes that emerged from the discussion was that the tradition model when use of services is stimulated by offering lucrative gift set in exchange for taking HIV tests cannot be sustained without donor funding and promotes dependency of SWs and MSMs from service providers rather than conscious responsibility for one’s health and well-being. Given that neither health system nor donor would be able to ensure universal coverage of key populations if the same model continues to be used, it is important to look for different approaches.

● **National execution**

Evaluation data indicates that though the amount and share of the CP budget executed by the national implementing partners was progressively declining (Fig. 10), UNFPA was consistently expanding the pool of national implementing partners while maintaining national execution through the MoHSP and the AS as well as NGOs TFPA and Apiron.

EQ7. To what extent have partnerships built with government or other UN organizations to enhance sustainability or scale up interventions and/or bring relevant evidence to policy-makers to adopt such approaches?			
Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
A7. Partnerships built with government or other UN organizations enabled UNFPA to enhance sustainability or scale up its interventions	<ul style="list-style-type: none"> Evidence of continued interventions Evidence of broader reach of interventions due to UNFPA partnerships with government, other UN agencies and other development agencies (USAID, GIZ, Mercy Corps) 	<ul style="list-style-type: none"> COARs 	Document review Interviews with: <ul style="list-style-type: none"> UNFPA CO staff Implementing partners National partners Members of UNCT USAID, GIZ, Mercy Corps

In most cases UNFPA operation is not project-based and UNFPA is able to provide long-term continuous support to ensure sustainable implementation and ongoing improvement of the practices introduced with its support.

Example 1: UNFPA support in the area of **family planning** (FP). This support started in late 1990s when UNFPA helped Tajikistan to establish its FP system. The evaluation team has met several national stakeholders who were involved in the establishment of this system in late 1990s and they were unanimous that UNFPA support was absolutely crucial. Since then UNFPA was supporting development and sustainable operation of the FP system by providing contraceptives, equipment and instruments, technology (operational standards), building capacity of service providers and strengthening national policy and regulatory frameworks related to FP.

Under the current CP to ensure sustainable operation of the FP system, especially uninterrupted access to contraceptives, and to increase availability of the contraceptive options to women in remote rural communities UNFPA was supporting the government of Tajikistan transition to assuming full responsibility for procurement and distribution of contraceptives (still ongoing), as well as building the capacity and reach of the RH system to provide family planning services.

Since 2015 Tajikistan is no longer eligible for UNFPA contraceptive assistance. UNFPA supported the government to establish a dedicated budget line in the MoHSP budget to procure contraceptives. In order to achieve this, UNFPA and the National Committee on PD made evidence-based arguments on cost-effectiveness of FP services as well as their importance for the country's development (realizing women's potential and making investments in children) and advocated for the state budget allocation. UNFPA also identified a potential donor (Government of Japan) who can contribute to supplement funds from UNFPA and Tajikistan to secure sufficient financial resources to procure contraceptives. This encouraged the Government to allocate state budget and make gradual increase in its budget allocation to demonstrate the national ownership of the FP programme through the USD2.7 mln Joint Project on Strengthening National FP Services for 2017-2020. In parallel, UNFPA and USAID supported situation analysis on FP, the findings and recommendations of which helped to develop a first-ever costed State Programme on RH for 2019-2022 as a state-funded strategy to close the unmet need for FP. The MoHSP and UNFPA also developed a National Communication Strategy for FP as a framework of communication intervention toward the population. The major focus of both strategic papers is reaching young people, who constitute a large proportion of the population in Tajikistan, and ensuring that all communication activities are geared toward common objective of adopting healthy and responsible behavior and increasing voluntary uptake of appropriate FP methods.

UNFPA has also supported strengthening of national logistics information and management system used to distribute contraceptives. In 2017, 20 participants from the selected districts of Khatlon region were trained on the essentials of logistics management and information system for contraceptive distribution, including practical application of logistics software CHANNEL. In 2018 the national system was adjusted based on the results of the review of the existing regulation (MoHSP Order #480 on Logistics Management Information System) and the new regulation was established providing specific roles and responsibilities for PHC and Hospital Managers and RH Center Directors in the management of contraceptive means, guidelines on management of medical and contraceptive means, guidelines on management of warehouses, application of logistics software and etc.

UNFPA has also supported sustainability and greater reach of family planning services, especially to remote areas. In 2017-2019, UNFPA supported training on IUD insertion and removal for 60 midwives working at Health Houses in remote rural communities and two trainings on postpartum contraception for 40 midwives from maternity houses of Sudgh and Khatlon provinces. In 2018, UNFPA supported the development of the clinical protocol on the post-partum IUD insertion. During the field visits the evaluation team has found that both a new protocol and skills gained through UNFPA supported training event are being used.

Example 2: the **use of evidence-based clinical protocols and near-miss case review (NMCR)** by maternal health service providers. These approaches were approved by the MoHSP in 2008-2012 mainly with advocacy and technical support of UNFPA and further several international organizations joined to this initiative within strategic partnership. Under the current CP UNFPA is supporting sustainable implementation of these approaches. For example, in 2017 UNFPA supported visits of national experts 15 maternity houses of Sugdh, Khatlon and DDRs to monitor implementation of national standards and mentor staff. In 2018 UNFPA supported national coordinators of National BTN Committee to do monitoring and mentoring visits to four maternity houses in Sugdh province to ensure quality use of near-miss case reviews. National conference on launching of the second National Report of NMCR is conducted in 2018 with UNFPA support. This experience is presented in WHO/UNFPA International conference in Bishkek by national team of coordinators. UNFPA is also supporting annual meetings of staff of maternity clinics using near-miss case reviews. According to members of near-miss case review committees interviewed by the evaluation team, while they fully own the near-miss case review and use it consistently, monitoring visits and meetings are crucial for sustainability of NMCR use because they facilitate experience exchange and reinforce motivation. Annual meeting are also reportedly used to expose representatives of new maternity clinics to NMCR and thus promote its broader use in the country.

Example 3: sustainable operation of **gender-based violence victim support rooms (GBV VSR)**. Eight rooms were established with UNFPA support at regional and district maternity clinics in 2013. Operation of VSRs are fully institutionalized by the MoHSP orders, clinics keep official records of service provision, including identification of the types of violence a woman using VSR was subject to. Clinics have designated staff in charge of VSR operation (but no designated job positions) and cover operational expenses, mostly food, bed, clothes and medicine from clinic budgets.

The evaluation has found that heads of host maternity clinics are committed to support VSR operation. They regularly promote availability of VSR through mass media. One of the host hospitals have reported to the evaluation team that when the demand for VSR use exceed its capacity, they put BGD victims to regular hospital wards. In one the clinics women using VSR were offered professional training (on sewing) and landing jobs, including at the host clinic. Clinic heads are also using their contacts with the staff of the primary health care facilities and reproductive health centers throughout the province to ensure that they follow with a woman when she leaves the VSR.

Heads of visited host clinics reported that in the framework of the current CP UNFPA supported their participating in cross visits on gender equality, which was useful in terms of exchange of ideas, and making VSRs more welcoming and comfortable for women and their children. As per information of National RH Center 860 victims of GBV were served by eight VSRs in the period of 2012-2019.

Low operational costs of practices introduced with UNFPA facilitate their sustainable implementation by government institutions.

Institutionalization of a practice/service introduced with UNFPA support through national regulations, including accountability of service providers to the relevant ministry, does not automatically translate into allocation of designated funding to support service provision. As a result only practices/services that can be implemented with no or low additional expenses become sustainable.

CO approached EPC technology as one of cost effective, internationally recognized programme that was most relevant to Tajikistan context considering insufficient funds in health sector.

Implementation of near-miss case reviews at the level of maternity clinics does not involve any financial costs for a clinic and many of the NMCR recommendations are implemented at a relatively low cost. This is one of the factors that explains why the evaluation team has found many cases of sustainable use of NMCR. At the same time the evaluation team has observed that the second part of Beyond the Number initiative on confidential review of maternal deaths has become less organized due to lack of management by the National Association of Ob/GYNs because of frequent staff changes in the Association board (who is responsible for audit of maternal death), lack of knowledge of new comers. Renewed Association lacked partnership with development partners. In addition, specialists who were given the task to conduct reviews had to do it on top of their regular functions. However, more importantly, the review involves travels and making copies of multiple documents, and these expenses were not covered by the state budget.

UNFPA's lead economic analysis on effectiveness of procuring contraceptives through UNFPA for policy-decision makers, resulted with the decision of the Government to procure contraceptives through UNFPA Procurement services at relatively low prices that has also reduced both operational and market provided costs.

HLS course introduced to schools under Adolescents and Youth component of the CP is based on the interactive training methodology which involves use of flipcharts and markers. Some teachers have reported to the evaluation team that schools don't have funds to purchase these materials. As a result, some teachers don't use the methodology. Those who do buy materials themselves or solicit support from parents (both money and in kind).

Still regulatory institutionalization of practice/service in maternal health introduced with UNFPA promotes both its sustainability and scale up through support of other development partners. For example, USAID Feed the Future Project (2017-2019) supported quality implementation of clinical protocol and NMCR in maternity clinics in six districts of Khatlon province. New JICA Project for Improving Maternal and Child Health Care System in Khatlon Oblast Phase 2 plans to support use of NMCR in another six districts of Khatlon province.

Factors that affect sustainability on UNFPA supported interventions include high staff turnover, lack of understanding in policy application by state institutions

In addition to the lack of designated state funding, the evaluation has found several other factors that affect sustainability of introduced practices/services. One is **high staff turnover** in the state sector. For example, as a result of the cervical screening pilot project every health facility in the two target districts had a specialist (a doctor, a midwife or a nurse) trained to do screening. The project was completed in 2018. In the fall of 2019, one year after the project completion, this evaluation has found that in one of pilot districts about 30% of trained midwives and nurses have already left. In the opinion of interviewed national stakeholders, staff turnover is one of key reason for insufficient implementation of NMCR in some hospitals. The same situation is observed in district RH Centers that trained doctors are leaving for labor migration to Russian Federation.

Lack of coordination in policy application by state institutions can also be a reason for undermined sustainability of results of UNFPA interventions. The evaluation team has found that in the end of 2018 MoHSP issued instruction that any surgical manipulation can be provided only if a patient has been recently tested for HIV and hepatitis. This is also resulted in IUD insertion that women who want to have IUD inserted have to take HIV and hepatitis tests for a fee of 90 somoni. This becomes a serious barrier to many women already leading to reduced use of IUDs. However, National RH Center could not provide any evidence on this instruction that is mean that there were no Order by MoHSP. This need to be studied in the future, as there are different opinions among services providers on relevance of mandatory pre-IUD testing to HIV.

The evaluation data also suggests that design of interventions supported by TGF under the HIV prevention component indirectly may promote dependency of beneficiaries on service provision which undermines sustainability on the long run. For example, to motivate key pop for HIV test, people were stimulated by food packages. Representative of SWs and MSMs interviewed by the evaluation team were deeply disappointed that their “privileges” were removed when the project ended and were not ready to use regular services offered by the state which are not free of charge. This pattern was discussed at the round table in Khujand that the evaluation team was able to attend. In the course of this discussion one of NGO representatives commented that the project might have avoided building dependency pattern if it had paid more attention to promoting the feeling of self-responsibility for one’s health among targeted key populations from the very beginning. UNFPA is a recipient only and this concern was communicated to donor. It is recommended to discuss this during next round of TGF funding.

Government institutions organize their internal training events, which contributes towards scaling up the reach of capacity building interventions supported by UNFPA.

The evaluation has found examples when government partners scale-up the reach of capacity building interventions supported by UNFPA. The AS is organizing internal training events for staff of its district offices to disseminate knowledge and skills related to census implementation gained by the staff of its regional offices through training organized by UNFPA CP. Sustainability of these capacity development efforts are also undermined by high staff turnover because of low salaries.

Medical specialists also reported to the evaluation team that they share knowledge and materials obtained at UNFPA supported training events with colleagues. Some district level RH centers and maternity clinics organize regular training for the staff to ensure proper use of national standards and protocols, including those developed with UNFPA support.

One the teachers who participated in HLS training reported to the evaluation team that she delivered demonstrations of HLS sessions attended by teachers from remote locations who were not involved in the project. Visits were organized by regional authorities. A deputy principal in charge of extracurricular education reported that after attending HLS training supported by the CP she organized HLS training at her school for all class coordinators.

EQ8.To what extent has the UNFPA country office contributed to the functioning and consolidation of UNCT coordination mechanisms?			
Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
8.1. UNFPA country office has significantly contributed to the functioning and consolidation of UNCT coordination mechanisms	<ul style="list-style-type: none"> Evidence of contribution to functioning and consolidation of UNCT coordination mechanisms 	<ul style="list-style-type: none"> Partnership plan Reports on implementation of partnership plan UNDAF 	Documents review Interviews with: <ul style="list-style-type: none"> INFPA CO staff UNCT members

In 2016-2019 UNFPA CO participated in and contributed to all UNCT coordination mechanisms, including Operations Management Team, Theme Groups, UNDAF Result Group, REACT. UNFPA CO contribution is recognized by other agencies and RCO, but an absence of appointed AR since the end of 2018 undermines CO capacity to maintain its leadership within the UNCT.

Operations Management Team: In 2016 when UNFPA chaired the OMT it initiated the development of the UNCT business operations strategy, harmonization of activities between UN Agencies, and analysis of the state procurement system.

Youth Theme Group: The group was established in January 2013 due to UNFPA initiative. UNFPA co-chaired the groups. In the opinion of the UNCT members because of UNFPA leadership initially the YTG was very active and instrumental in terms of initiating joint activities, like celebration of the International Day of the Girl Child. UNCT members regret the current decline in the YTG activity and believe that UNFPA CO leadership is important to make it active again.

UNDAF Result Groups: UNFPA along with UN Woman co-chairs Result Group 5: Inclusion and Empowerment of Vulnerable Groups. In this capacity UNFPA was instrumental in preparation of the national VNR. UNFPA is also a member of Result Groups 1, 3, 6 and M&E RG.

Partnership and joint programming: In the course of the current country programme UNFPA contributed towards implementation of several joint projects: “Support to Civil Registration System Reform in Tajikistan” implemented in partnership with UNDP (that is a lead agency implementing this project) and UN Women with financial support of the Swiss Direction for Cooperation; and “HIV Prevention among Sex Workers (SW) and Men Who Have Sex with Men (MSM) in Tajikistan” project implemented in partnership with UNDP (a lead agency for this project) ad funded by the Global Fund. UNFPA also contributed to the development of Resilience and Vulnerability Atlas led by UNDP. At the time of the filed phase of this evaluation UNFPA CO was actively involved in the development of the UNCT proposal to the EU Spotlight Initiative.

Facilitating support of UNCT members to the Census 2020: UNFPA is facilitating contribution of UNCT members towards the Population and Housing Census 2020. In June 2019 UNFPA convened a round table that presented Census 2020 potential in terms of measuring SDGs indicators, including capturing data on such complex issues as statelessness, migration and disability. As a result, several UNCT members expressed interest to support the Census 2020, including UNICEF and IOM⁵³ (UNFPA (2019)).

Joint UNCT advocacy efforts: UNFPA plays important role in UNCT joint advocacy efforts, e.g. 16 Days of Activism Against Gender-Based Violence campaign.

EQ9. What is the main UNFPA added value in the country context as perceived by UNCT and national stakeholders?

⁵³ UNFPA (2019). Report on the Round table “Population and housing census 2020: advocacy and resource mobilization”, June 2019

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
9.1. UNFPA added value in the as perceived by UNCT and national stakeholders.	<ul style="list-style-type: none"> • Added value as perceived by UNCT • Added value as perceived by national stakeholders 		Interviews with: <ul style="list-style-type: none"> • UNCT members • All national stakeholders

In the opinion of **UNCT members**, UNFPA added value comes from its thematic leadership, especially in the SRH sector, and its ability to maintain a balance between pursuing its mandate and ensuring national ownership of its work.

For **national stakeholders**, UNFPA added value comes from continuity of its efforts. Unlike many other development agencies UNFPA does not do standalone short projects, but provides continuous support in the areas that fall under its mandate: e.g. UNFPA has been supporting the development of the Tajikistan family planning system since 1998, the use of near miss cases review to reduce maternal mortality – since 2012.

Many national stakeholders perceive UNFPA as the only agency that provides support in the areas of maternal health and family planning.

UNFPA flexibility and responsiveness:

- “They hear us. There are development partners with a rigid mandate. UNFPA had a broad mandate and they are open to our needs” (National partner).
- “UNFPA was always responsive to the needs of the Ministry of Health, and they are able to respond promptly, to the extent that they changed their annual work plans” (National partner)
- “UNFPA CO is very friendly and flexible” (Implementing partner)
- “I like UNFPA CO for its flexible and ready to help us” (NGO implementing partner)

Annex 6: Data collection instruments

Интервью с руководящими сотрудниками национальных партнеров и implementing partners

Информированное согласие	<p>Здравствуйте!</p> <p>Спасибо, что согласились встретиться.</p> <p>Меня зовут, это мои коллеги</p> <p>Мы делаем оценку текущей страновой программы Фонда народонаселения ООН, которая реализуется с 2016 года.</p> <p>Задачи оценки – проанализировать работу странового офиса Фонда народонаселения ООН и достигнутые результаты, а также дать рекомендации относительно следующей программы.</p> <p>В рамках этой оценки мы встречаемся с разными людьми, которые так или иначе участвовали в реализации программы. На основании собранной в ходе этих встреч информации будет подготовлен отчет о результатах оценки.</p> <p>Мы будем признательны вам, если вы поделитесь с нами своим опытом участия в программе.</p> <p>У нас к вам будет ряд вопросов, и, с вашего позволения, мы будем вести записи во время разговора.</p> <p>Кроме того, мы должны указать в отчете, с кем мы встречались в ходе оценки, поэтому нам нужно будет записать ваши фамилию и должность. Но других ссылок на вас в отчете не будет: если мы будем использовать в тексте отчета цитаты из нашего с вами разговора, мы не будем указывать, кто конкретно это сказал.</p> <p>Вы можете не отвечать на любой из наших вопросов и можете прервать интервью в любой момент.</p> <p>Если у вас будут какие-то вопросы к нам, мы постараемся на них ответить – в рамках своих компетенций.</p>
Записать ФИО и должность собеседников	<ul style="list-style-type: none"> • С вашего позволения, я запишу ваши имя и должность.
	<ul style="list-style-type: none"> • Как давно вы работаете в этой организации? • Что входит в круг ваших обязанностей?
Effectiveness	<ul style="list-style-type: none"> • По каким направлениям ваша организация сотрудничала с ЮНФПА в рамках страновой программы 2016-2020? • Что является основными результатами данного сотрудничества?
Added value	<ul style="list-style-type: none"> • Можно было бы получить данные результаты без поддержки ЮНФПА?
Sustainability	<ul style="list-style-type: none"> • Сохранятся ли полученные результаты без поддержки ЮНФПА? Будет ли продолжена начатая деятельность без поддержки ЮНФПА?
Efficiency	<ul style="list-style-type: none"> • На ваш взгляд, насколько рационально ЮНФПА использует имеющиеся у него ресурсы (человеческие, финансовые)? • Какие формы работы, используемые ЮНФПА, являются наиболее эффективными, на ваш взгляд? • Как можно было бы сделать работу ЮНФПА более эффективной?
Разработка страновой программы – Relevance	<ul style="list-style-type: none"> • Участвовали ли вы в разработке страновой программы 2016-2020? <p>Если да:</p> <ul style="list-style-type: none"> • Каким образом проходил процесс разработки программы?
Relevance	<ul style="list-style-type: none"> • Насколько в страновой программе учтены потребности и приоритеты Таджикистана? • Какие вопросы и группы населения не получили достаточного внимания?

Added value	<ul style="list-style-type: none"> • Что, на ваш взгляд, является наиболее сильными сторонами ЮНФПА и его работы в стране? Приведите примеры. • Видите ли вы какие-либо слабые стороны в работе ЮНФПА?
Comparative advantage	<ul style="list-style-type: none"> • Сотрудничает ли ваша организация с другими агентства ООН и агентствами развития и международными НКО (например, USAID, GIZ, EU, Mercy Corps, и другие)? • Если да, видите ли вы какие-то различия между тем, как работает ЮНФПА, и тем, как работают другие агентства ООН и агентства развития?
Cooperation (если организация работает с несколькими агентствами ООН)	<ul style="list-style-type: none"> • На ваш взгляд, насколько хорошо агентства ООН координируют между собой свою работу?
Рекомендации	<ul style="list-style-type: none"> • Какие направления и формы работы вы бы порекомендовали ЮНФПА включить в следующую программу (после 2020 года)?
Закрытие	<p>Спасибо за помощь.</p> <p>Может быть, у вас есть к нам какие-то вопросы?</p>

Интервью со специалистами, которые участвовали в обучающих мероприятиях в рамках программы

Нужно иметь с собой список семинаров, в которых могли участвовать респонденты

Информированное согласие	<p>Здравствуйте!</p> <p>Спасибо, что согласились встретиться.</p> <p>Меня зовут ..., это мои коллеги</p> <p>Мы делаем оценку текущей страновой программы Фонда народонаселения ООН, которая реализуется с 2016 года.</p> <p>Задачи оценки – проанализировать работу странового офиса Фонда народонаселения ООН и достигнутые результаты, а также дать рекомендации относительно следующей программы.</p> <p>В рамках этой оценки мы встречаемся с разными людьми, которые так или иначе участвовали в реализации программы. На основании собранной в ходе этих встреч информации будет подготовлен отчет о результатах оценки.</p> <p>Мы будем признательны вам, если вы поделитесь с нами своим опытом участия в программе.</p> <p>У нас к вам будет ряд вопросов, и, с вашего позволения, мы будем вести записи во время разговора.</p> <p>Кроме того, мы должны указать в отчете, с кем мы встречались в ходе оценки, поэтому нам нужно будет записать ваши фамилию и должность.</p> <p>Но других ссылок на вас в отчете не будет: если мы будем использовать в тексте отчета цитаты из нашего с вами разговора, мы не будем указывать, кто конкретно это сказал.</p> <p>Вы можете не отвечать на любой из наших вопросов и можете прервать интервью в любой момент.</p> <p>Если у вас будут какие-то вопросы к нам, мы постараемся на них ответить – в рамках своих компетенций.</p>
Записать ФИО и должность собеседников	<ul style="list-style-type: none"> • С вашего позволения, я запишу ваши имя и должность.
	<ul style="list-style-type: none"> • Как давно вы работаете в этой организации?

	<ul style="list-style-type: none"> • Что входит в круг ваших обязанностей?
Effectiveness	<ul style="list-style-type: none"> • В каких обучающих мероприятиях, организованных ЮНФПА в 2016-2019 годах вы принимали участие? • Насколько новыми для вас были полученные знания и навыки?
Added value	<ul style="list-style-type: none"> • Можно было бы получить данные знания без поддержки ЮНФПА?
Effectiveness	<ul style="list-style-type: none"> • Как вы использовали полученные знания и навыки? Какие получили результаты? • Если человек не использовал – Почему не использовали?
Sustainability	<ul style="list-style-type: none"> • Продолжаете ли вы использовать полученные знания и навыки? • Если человек перестал использовать – Почему перестали использовать?
Efficiency	<ul style="list-style-type: none"> • На ваш взгляд, насколько рационально были организованы обучающие мероприятия, в которых вы участвовали • Как можно было бы сделать их более эффективными?
Рекомендации	<ul style="list-style-type: none"> • Какие направления и формы работы вы бы порекомендовали ЮНФПА включить в следующую программу (после 2020 года)?
Закрытие	Спасибо за помощь. Может быть, у вас есть к нам какие-то вопросы?

Интервью с учителем, который преподает курс ЗОЖ

Информированное согласие	
Записать ФИО и должность собеседников	С вашего позволения, я запишу ваши имя и должность.
Effectiveness	<ul style="list-style-type: none"> • Как получилось, что вы прошли обучение по преподаванию курса ЗОЖ? • Было ли полученных знаний достаточно для ведения этого курса в школе? • Как к появлению этого предмета отнеслись дети? • А их родители?
Sustainability	<ul style="list-style-type: none"> • Будете ли преподавать данный курс в этом году? • Нужна ли вам какая-то дополнительная поддержка, чтобы продолжать преподавать данный курс?
Рекомендации	<ul style="list-style-type: none"> • Нужно ли как-то изменить содержание курса? Почему?
Relevance	<ul style="list-style-type: none"> • Вы знаете, что в стране созданы дружественные к молодежи консультационные центры, где подростки могут получить консультации по вопросам репродуктивного здоровья? • Что вы думаете о данной инициативе? • Рекомендуете ли вы своим ученикам туда обращаться?
Закрытие	Спасибо за помощь. Может быть, у вас есть к нам какие-то вопросы?

Фокус-группа со школьниками, которые посещали курс ЗОЖ

Информированное согласие	Здравствуйтесь! Спасибо, что согласились встретиться. Меня зовут ..., это мои коллеги Мы делаем оценку текущей страновой программы Фонда народонаселения ООН, которая реализуется с 2016 года.
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	<p>В рамках программы учителей школ обучали тому, как преподавать предмет ЗОЖ.</p> <p>Мы попросили организовать нам встречу со школьниками, которые прошли данный курс, то есть с вами, чтобы узнать ваше мнение о данном курсе, был ли он вам чем-то полезен.</p>
Актуализация опыта	<ul style="list-style-type: none"> • Расскажите, пожалуйста, какие темы вы проходили в рамках курса ЗОЖ?
Effectiveness	<ul style="list-style-type: none"> • Вы узнали что-то новое на уроках ЗОЖ? • Была какая-то полезная информация, которая вам уже пригодилась? • Вы рассказывали родителям, что изучаете ЗОЖ в школе? Как они к этому отнеслись?
Рекомендации	<ul style="list-style-type: none"> • Нужно ли как-то изменить содержание курса? Почему?
Relevance	<ul style="list-style-type: none"> • Знаете ли вы, что в стране созданы дружественные к молодежи консультационные центры, где подростки могут получить консультации по вопросам репродуктивного здоровья? • Что вы думаете о данной инициативе? • Если у вас знакомые, которые уже туда обращались?
Закрытие	<p>Спасибо за помощь.</p> <p>Может быть, у вас есть к нам какие-то вопросы?</p>

Интервью с молодыми людьми, которые посещают медицинские центры, дружественные молодежи

Участие анонимное – Протокол заполняется после разговора

Информированное согласие	<p>Здравствуйте!</p> <p>Меня зовут, это мои коллеги</p> <p>Мы делаем оценку текущей страновой программы Фонда народонаселения ООН, которая реализуется с 2016 года. Программа, в том числе, помогла создать центры, дружественные молодежи, - как тот, где мы сейчас находимся.</p> <p>Не могли бы вы ответить нам несколько вопросов?</p>
	<ul style="list-style-type: none"> • Как вы узнали о центре, дружественном молодежи? • Насколько вы довольны полученными услугами? • Как вы думаете, многие из ваших друзей и одноклассников знают о том, что есть такой центр и сюда можно обратиться за помощью?
Обучение ЗОЖ	<ul style="list-style-type: none"> • Вы учитесь в школе? • Если да – У вас был предмет ЗОЖ? • Если да – Узнали ли вы на этих уроках что-то полезное? • Если нет – Как вы думаете, нужен в школе такой курс?
Закрытие	<p>Спасибо за помощь.</p> <p>Может быть, у вас есть к нам какие-то вопросы?</p>

Интервью с женщинами, которые воспользовались услугами комнат для жертв насилия

Участие анонимное – Протокол заполняется после разговора

Информированное согласие	<p>Здравствуйте!</p> <p>Меня зовут,</p>
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	Мы делаем оценку текущей страновой программы Фонда народонаселения ООН, которая реализуется с 2016 года. Программа, в том числе, помогла создать комнаты помощи, как та, услугами которой вы воспользовались. Не могли бы вы ответить нам несколько вопросов?
	<ul style="list-style-type: none"> • Как вы узнали о существовании комнат? • Насколько вы довольны полученными услугами? • Если бы такой комнаты не было, могли бы вы еще где-то получить подобные услуги? • Нужно ли что-то изменить в том, как работают комнаты?
Закрытие	Спасибо за помощь. Может быть, у вас есть к нам какие-то вопросы?

Фокус-группа с секс-работницами и МСМ

Участие анонимное

Информированное согласие	Здравствуйте! Меня зовут, Мы делаем оценку текущей страновой программы Фонда народонаселения ООН, которая реализуется с 2016 года. Программа, в том числе, помогла создать центры доверия, услугами которых вы пользовались. Не могли бы вы ответить нам несколько вопросов относительно вашего опыта пользования центрами?
	<ul style="list-style-type: none"> • Как вы узнали о существовании центров доверия? • Насколько вы довольны полученными услугами? • Если бы такого центра не было, могли бы вы еще где-то получить подобные услуги?
Закрытие	Спасибо за помощь. Может быть, у вас есть к нам какие-то вопросы?

Встречи с девочками и женщинами в селах, где проходили Ярмарки здоровья

Участие анонимное

Информированное согласие	Здравствуйте! Меня зовут, Мы делаем оценку текущей страновой программы Фонда народонаселения ООН, которая реализуется с 2016 года. Говорят, в прошлом году у вас проходила Ярмарка здоровья. Не могли бы вы ответить нам несколько вопросов относительно вашего участия в этой ярмарке?
	<ul style="list-style-type: none"> • Какие услуги вы получили на ярмарке? • Насколько вы довольны полученными услугами? • Если бы ярмарки не было, могли бы вы еще где-то получить подобные услуги? • Какую помощь вы получаете в центре здоровья вашего села? • Каких услуг вам не хватает?

Закрытие	Спасибо за помощь. Может быть, у вас есть к нам какие-то вопросы?
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Интервью с сотрудниками офиса ФНН ООН

Informed consent/ Информированное согласие	<p>Здравствуйте!</p> <p>Спасибо, что согласились встретиться.</p> <p>Меня зовут, это мои коллеги</p> <p>Мы делаем оценку текущей страновой программы Фонда народонаселения ООН, которая реализуется с 2016 года.</p> <p>Задачи оценки – проанализировать работу странового офиса Фонда народонаселения ООН и достигнутые результаты, а также дать рекомендации относительно следующей программы.</p> <p>В рамках этой оценки мы встречаемся с разными людьми, которые так или иначе участвовали в реализации программы. На основании собранной в ходе этих встреч информации будет подготовлен отчет о результатах оценки.</p> <p>Мы будем признательны вам, если вы поделитесь с нами своим опытом участия в программе.</p> <p>У нас к вам будет ряд вопросов, и, с вашего позволения, мы будем ввести записи во время разговора.</p> <p>Кроме того, мы должны указать в отчете, с кем мы встречались в ходе оценки, поэтому нам нужно будет записать ваши фамилию и должность. Но других ссылок на вас в отчете не будет: если мы будем использовать в тексте отчета цитаты их нашего с вами разговора, мы не будем указывать, кто конкретно это сказал.</p> <p>Вы можете не отвечать на любой из наших вопросов и можете прервать интервью в любой момент.</p> <p>Если у вас будут какие-то вопросы к нам, мы постараемся на них ответить – в рамках своих компетенций.</p> <p>Информация для ответа на вопросы</p>
Сбор базовой информация о собеседнике	<ul style="list-style-type: none"> • Записать ФИО и должность • Как давно вы работаете в страновом офисе? • Что входит в круг ваших обязанностей? • Где вы работали раньше? (другие агентства ООН, госорганы) <p>Участвовали ли вы в разработке текущей страновой программы? (если человек работал в офисе в 2014-2015 гг)</p>
Соответствие (Relevance) – разработка страновой программы	<p>Если человек участвовал в разработке текущей страновой программы:</p> <ul style="list-style-type: none"> • Как проходила разработка текущей страновой программы? • Каким образом на этапе разработки происходила координация содержания страновой программы ЮНФПА со Стратегическим планом, с UNDAF, со страновыми программами других агентств ООН? • На ваш взгляд, в контексте мандата ЮНФПА, какие группы населения Таджикистана являются наиболее уязвимыми? • В какой степени удалось учесть потребности этих групп при разработке страновой программы?
Соответствие (Relevance) – разработка годовых планов работы	<ul style="list-style-type: none"> • Каким образом проходит разработка ежегодных планов работы по проектам? • На основании чего принимаются решения о том, какие мероприятия должны быть включены в план?

	<ul style="list-style-type: none"> С какими трудностями страновой офис сталкивался на этапе разработки и согласования ежегодных планов работы? <p>Каким образом происходит координация планов работы с другими агентствами ООН?</p>
Реализация планов (результативность и использование ресурсов)	<ul style="list-style-type: none"> Каким образом были разделены функции по реализации проектов между страновым офисом ЮНФПА и implementing partners? Каким образом к работе подключались другие агентства ООН, когда это было предусмотрено? Какие факторы повлияли – позитивно и негативно – на реализацию запланированных мероприятий? <p>Насколько реформа офиса повлияла на реализацию программы?</p>
Результаты программы	<ul style="list-style-type: none"> На ваш взгляд, что является основными результатами программы в сферах репродуктивного и материнского здоровья, образования по вопросам репродуктивного здоровья, продвижения интересов молодежи, использования данных? Можно ли говорить о каких-то позитивных изменениях в использовании услуг в области репродуктивного здоровья молодыми людьми и наиболее уязвимыми группами населения?
UNFPA comparative strengths + sustainability	<ul style="list-style-type: none"> В чем, на ваш взгляд, основные сильные стороны ЮНФПА? В какой степени эти сильные стороны востребованы правительственными структурами? Приведите примеры. В какой степени эти сильные стороны востребованы другими агентствами ООН? Приведите примеры. Есть ли примеры, когда какие-то инициативы ЮНФПА были продолжены или расширены правительством? <p>Есть ли примеры, когда какие-то инициативы ЮНФПА были продолжены или расширены другими агентствами ООН?</p>
Закрытие интервью	Есть ли какие-то важные моменты, которые мы с вами не обсудили?

Интервью с другими агентствами ООН и агентствами развития

Informed consent/ Информированное согласие	<p>Здравствуйтесь!</p> <p>Спасибо, что согласились встретиться.</p> <p>Меня зовут ..., это мои коллеги</p> <p>Мы делаем оценку текущей страновой программы Фонда народонаселения ООН, которая реализуется с 2016 года.</p> <p>Задачи оценки – проанализировать работу странового офиса Фонда народонаселения ООН и достигнутые результаты, а также дать рекомендации относительно следующей программы.</p> <p>В рамках этой оценки мы встречаемся с разными людьми, которые так или иначе участвовали в реализации программы. На основании собранной в ходе этих встреч информации будет подготовлен отчет о результатах оценки.</p> <p>Мы будем признательны вам, если вы поделитесь с нами своим опытом участия в программе.</p> <p>У нас к вам будет ряд вопросов, и, с вашего позволения, мы будем ввести записи во время разговора.</p> <p>Кроме того, мы должны указать в отчете, с кем мы встречались в ходе оценки, поэтому нам нужно будет записать ваши фамилию и должность.</p> <p>Но других ссылок на вас в отчете не будет: если мы будем использовать</p>
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	<p>в тексте отчета цитаты их нашего с вами разговора, мы не будем указывать, кто конкретно это сказал.</p> <p>Вы можете не отвечать на любой из наших вопросов и можете прервать интервью в любой момент.</p> <p>Если у вас будут какие-то вопросы к нам, мы постараемся на них ответить – в рамках своих компетенций.</p>
Сбор базовой информация о собеседнике	<ul style="list-style-type: none"> • Записать ФИО и должность • Как давно вы работаете в страновом офисе этой организации ООН? • Что входит в круг ваших обязанностей? • Где вы работали раньше? (другие агентства ООН, госорганы)
Партнерские проекты с ЮНФПА	<ul style="list-style-type: none"> • Начиная с 2016 года были ли у вашего агентства совместные проекты с ЮНФПА? • Если были, кто был их инициатором? • Какую роль играло ваше агентство? • Какую роль играло ЮНФПА? • Какую роль играли национальные партнеры? • Какие основные результаты были получены?
Роль ЮНФПА в координации – для ООН	Как бы вы могли охарактеризовать роль, которую страновой офис ЮНФПА играет в процессах координации между агентствами ООН?
Added value	На ваш взгляд, в чем уникальность и основные сильные стороны ЮНФПА для Таджикистана? Приведите примеры.