

**UNFPA Country Programme Evaluation: Nepal  
2013-16**

**Final Evaluation Report**

**February 3<sup>rd</sup> 2017**

Chairperson, Chief Guest and all present here,  
I extend greetings, all warm and pleasant.

Hoping to be pardoned and also be advised in case of an error,  
I think I know, upon child marriage, a few words to deliver.

They had no knowledge about it in the past,  
People held the belief 'tis the religion in their grasp.

It's a crime straight, not a pious deed,  
It's a sin who vows it as a creed.

The main cause is considered, poverty and illiteracy,  
On that account a child girl conceives a baby.

Life has to suffer and offspring to rise,  
Mother and baby fall ill 'n that causes untimely demise.

Spiritual leaders, preachers, prophets and priests,  
Let's get united to fight against this evil practice.

Politicians, social workers, ladies and gentleman,  
Let's work actively to fight against this ill-tradition.

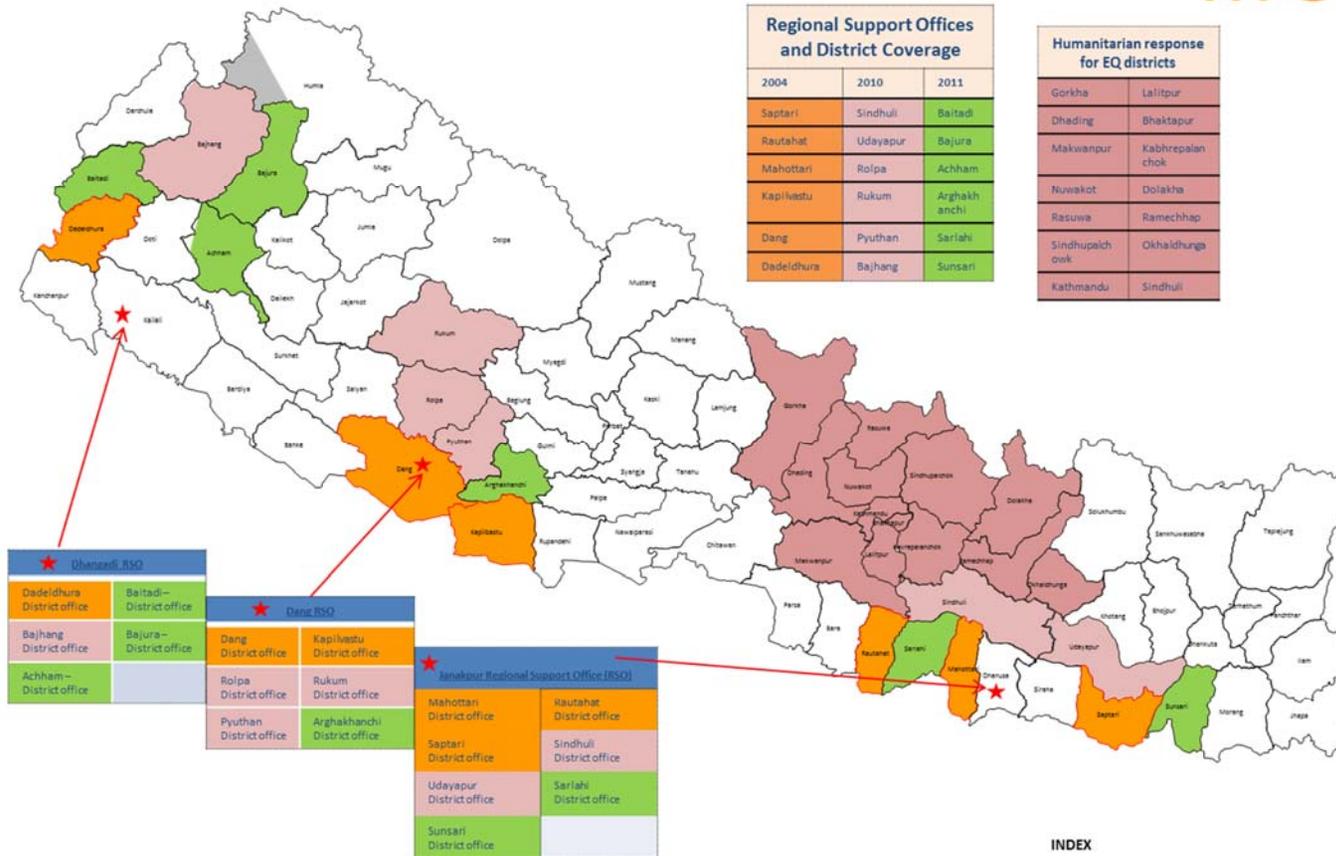
Many thanks are due to the organizer and the rest,  
Let me bid you good bye, wishing all the best.

*Poem Composed by Mr Hari Prasad Joshi, Secretary of Prestigious Priest Group, Baitadi,  
and Recited on Occasion of CPE Focus Group Discussion on September 11<sup>th</sup> 2016  
(translated from Nepali)*

# Map of Nepal

\* With UNFPA-supported districts

## UNFPA 7th Country Programme (2013-2017)



2004 Districts	Expansion Districts 2010	Expansion Districts 2011	EQ response Districts 2015

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## Abbreviations and Acronyms

AFHS	Adolescent-friendly health services
ANM	Auxiliary Nurse Midwife
APRO	UNFPA Regional Office for Asia and the Pacific
ASRH	Adolescent sexual and reproductive health
AWP	Annual Work Plan
BPKIHS	B.P. Koirala Institute of Health Sciences
CAC	Citizens' Awareness Centre
CBS	Central Bureau of Statistics
CDPS/TU	Central Department of Population Studies of the Tribhuvan University
CCPE	Clustered country programme evaluation of UNFPA's engagement in highly-vulnerable situations
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CERF	UN Central Emergency Response Fund
CMR	Clinical Management of Rape
CO	UNFPA country office
CP	Country programme
CPAP	Country programme action plan
CPD	Country programme document
CPE	Country programme evaluation
CPR	Contraceptive prevalence rate
CP7	UNFPA Nepal 7 <sup>th</sup> country programme of assistance
CRR	Centre for Reproductive Rights
CRVS	Civil Registration and Vital Statistics
CSE	Comprehensive sexuality education
CVICT	Centre for Victims of Torture Nepal
DDC	District Development Committee
DDRC	District Disaster Relief Committee
DEO	District Education Office
DEX	UNFPA direct execution
DHO	District Health Office
DHS	Demographic and Health Survey
DoE	Department of Education
DPMAS	District Planning, Monitoring and Analysis System
DPRP	District Disaster Preparedness and Response Plan
DWC	Department of Women and Children
EDCD	Epidemiology and Disease Control Division
EO	Evaluation Office
ERF	UNFPA Emergency Response Fund
ERG	Evaluation Reference Group
EQ	Evaluation question
FBARHCS	Facility-based Assessment for Reproductive Health Commodities and Services
FCHV	Female Community Health Volunteer
FFS	Female-friendly Space
FHD	Family Health Division
FP	Family planning
FSW	Female Sex Worker
FY	Fiscal Year
GBV	Gender-based violence
GBVEGEDCC	GBV Elimination and Gender Empowerment District Coordination Committees
GBVIMS	Gender-Based Violence Information Management System
GDP	Gross Domestic Product
GE	Gender equality
GoN	Government of Nepal

GPRHCS	Global Programme to Enhance Reproductive Health Commodity Security
HACT	Harmonized Approach to Cash Transfer
HCT	Humanitarian Country Team
HFOMC	Health Facilities Operation and Management Committee
HMIS	Health Management Information System
HQ	UNFPA headquarters
ICPD	International Conference on Population and Development
INFORM	Index for Risk Management
IRF	UNFPA Integrated Results Framework
JMMSS	Jagriti Mahila Mahasang National Network of Female Sex Workers
LARC	Long-Acting Reversible Contraception
LDMC	Local Disaster Management Committee
LGCDP	Local Governance and Community Development Programme 2013-17
LMD	Logistics Management Division
LMIS	Logistics Management Information System
MICS	Multiple Indicator Cluster Survey
MIDSON	Midwifery Society of Nepal
MISP	Minimum Initial Service Package
MMR	Maternal Mortality Ratio
MoE	Ministry of Education
MoF	Ministry of Finance
MoFALD	Ministry of Federal Affairs and Local Development
MoH	Ministry of Health
MoHP	Ministry of Health and Population (until 2015)
MoPE	Ministry of Population and Environment (since 2015)
MoWCSW	Ministry of Women, Children and Social Welfare
MoYS	Ministry of Youth and Sports
MPAs	Minimum Preparedness Actions
MTR	Mid-term Review
M&E	Monitoring and Evaluation
NDRF	National Disaster Response Framework
NEX	National execution
NFEC	Non-formal Education Centre
NFPPD	National Forum for Parliamentarians on Population and Development
NGO	Non-governmental Organization
NHEICC	National Health Education, Information and Communication Centre
NHSP	National Health Sector Programme 2010-2015
NHSS	National Health Sector Strategy 2016-2021
NHTC	National Health Training Centre
NLSS	Nepal Living Standards Survey
NNC	Nepal Nursing Council
NPC	National Planning Commission
NPR	Nepali Rupees
NRCS	Nepal Red Cross Society
NWC	National Women's Commission
OCMC	One-stop Crisis Management Centre
ODA	Official Development Assistance
OF	Obstetric fistula
OR	UNFPA Other Resources
PD	Population dynamics
PDNA	Post-Disaster Needs Assessment
RH	Reproductive health
RR	UNFPA Regular Resources
RRF	Results and Resources Framework
RRT	Rapid Response Team
RSO	UNFPA Regional Support Office
SBA	Skilled Birth Attendant

SFSP	Social and Financial Skills Package
SP	UNFPA Strategic Plan
SRH	Sexual and reproductive health
ToR	Terms of reference
UNCT	UN country team
UNDAF	UN Development Assistance Framework
UNDP	UN Development Programme
UNFPA	UN Population Fund
UNICEF	United Nations Children's Fund
UNYAP	UN Youth Advisory Panel
VAW	Violence against women
VDC	Village Development Committee
WCF	Ward Citizen Forum
WCO	Women and Children Office

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## Key Facts: Federal Democratic Republic of Nepal

Indicators	Facts	Source
<b>Land</b>		
Geographical location	Latitude 26° 22' N to 30° 27' N - longitude 80° 4' E to 88° 12' E	CBS (2014), Statistical Pocket Book of Nepal
Land area	147181 Sq.km.	CBS (2014), Statistical Pocket Book of Nepal
Terrain	Altitude ranges from a minimum of 70 meters to a maximum of 8,848 meters	CBS (2014), Statistical Pocket Book of Nepal
<b>People</b>		
Population	26.5m (2011)	CBS (2014), Population Monograph of Nepal, Vol. 1
Urban population	27.2% (2014)	CBS (2014), Population Monograph of Nepal, Vol. 1
Annual population growth rate	1.35% (2011)	CBS (2014), Population Monograph of Nepal, Vol. 1
<b>Government</b>		
Government type	Parliamentarian (in process to federal system)	
% of seats held by women in national parliament	29.5 (2015)	Millennium Development Goals Database: United Nations Statistics Division (24 February 2016): Seats held by women in national parliament <sup>1</sup>
<b>Economy</b>		
Per capita GDP USD	752 (p*) (2016)	GoN/MoF (2016), Economic Survey FY 2015-16 (p=preliminary estimates)
GDP growth rate (real GDP at basic prices)	0.77 (p*) (2016)	GoN/MoF (2016), Economic Survey FY 2015-16 (p=preliminary estimates)
Main industries	Tourism, carpet, textiles and agro-based industries	
<b>Social Indicators</b>		
Human Development Index	.490	GoN/UNDP (2014), Nepal Human Development Report 2014
Unemployment rate	2.1% (2008)	ILO (2014), Nepal Labour Market Update
Life expectancy at birth	66.6 years	CBS (2014), Statistical Pocket Book of Nepal
Under-5 mortality (per 1,000 live births)	52.9	CBS (2014), Population Monograph of Nepal, Vol. 1
Maternal mortality ratio (deaths of women per 100,000 live births)	258	WHO, UNICEF, UNFPA, World Bank Group (2015). Trends in Maternal Mortality: 1990-2015
Health expenditure (% of GDP)	5.3 (2014)	WHO, UNICEF, UNFPA, World Bank Group (2015). Trends in Maternal Mortality: 1990-2015
Births attended by skilled health personnel	55.6	CBS, MICS 2014, Key Findings. Kathmandu: Central Bureau of Statistics and UNICEF Nepal
Adolescent fertility rate (births per 1,000 women aged 15-19)	71	CBS, MICS 2014, Key Findings. Kathmandu: Central Bureau of Statistics and UNICEF Nepal

<sup>1</sup> <http://data.un.org/Data.aspx?q=nepal&d=MDG&f=seriesRowID%3A557%3BcountryID%3A524>.

Proportion of demand for contraception satisfied	66.3%	MICS 2014
Contraceptive prevalence rate (all methods)	49.6%	CBS, MICS 2014, Key Findings. Kathmandu: Central Bureau of Statistics and UNICEF Nepal
Contraceptive prevalence rate (modern methods)	47.1%	CBS, MICS 2014, Key Findings. Kathmandu: Central Bureau of Statistics and UNICEF Nepal
Unmet need for family planning	25.2	CBS, MICS 2014, Key Findings. Kathmandu: Central Bureau of Statistics and UNICEF Nepal
% of people living with HIV, 15-24 years old	0.03%	NCASC EPI Fact Sheet, 2015
% of people living with HIV, 15-49 years old	0.2%	NCASC EPI Fact Sheet, 2015
Adult literacy (% aged 15 and above)	57.4 (2008-2012)	UNICEF Nepal <sup>2</sup>
Primary gross enrolment ratio (m/f per 100)	38.06/40.23 (2011)	Ministry of Education, Government of Nepal (2015). Nepal Education in Figures: At A Glance
Gross enrolment ratio (m/f per 100)	97.6/91.0 (2007-2013)	World Statistics Pocketbook   United Nations Statistics Division: Nepal.
Gender Inequality Index (GDI)	0.908 (2014)	UNDP Human Development Report <sup>3</sup>
Gender-based violence (% women aged 15-49) Physical violence Sexual violence	22% 12%	Population Division Ministry of Health and Population Government of Nepal Kathmandu, Nepal. New ERA Kathmandu, Nepal and ICF International Calverton, Maryland, U.S.A. (March 2012) Nepal Demographic and Health Survey 2011

Note: Numbers in brackets denote reference period

<sup>2</sup> [http://www.unicef.org/infobycountry/nepal\\_nepal\\_statistics.html](http://www.unicef.org/infobycountry/nepal_nepal_statistics.html).

<sup>3</sup> <http://hdr.undp.org/en/composite/GD>.

## Structure of the Country Programme Evaluation Report

The present report comprises an executive summary, five chapters and annexes.

Chapter 1, the Introduction, provides the background to the evaluation, objectives and scope, the methodology used, including limitations encountered, and the evaluation process.

The second chapter describes the Nepal country context, including the challenges it faces in the UNFPA-mandated areas.

The third chapter outlines UNFPA's response to national challenges in sexual and reproductive health, gender equality and population dynamics, as well as in view of Nepal's high vulnerability to natural and other disasters.

Chapter 4 presents the findings of the evaluation for each of the evaluation questions, assumptions for assessment and indicators specified in the evaluation matrix.

Chapter 5 discusses conclusions and recommendations at the strategic and programmatic level.

Annexes (presented separately) round off the report.

## Executive Summary

### Purpose, Objectives and Scope of the Country Programme Evaluation

This evaluation of UNFPA's 7<sup>th</sup> country programme (CP7) of assistance to the Government of Nepal 2013-17 was commissioned as per the 2013 UNFPA Evaluation Policy and the UNFPA Transitional Biennial Budgeted Evaluation Plan 2014-15. Evaluation results are intended to demonstrate accountability. They are meant to support evidence-based decision taking. And they should contribute to UNFPA's knowledge base. The *specific objectives* are:

- (i) To evaluate the programmatic results of CP7 as well as UNFPA's strategic positioning in Nepal;
- (ii) To draw lessons on the relevance and performance of UNFPA-supported interventions;
- (iii) To propose a set of recommendations with regard to programming strategies and operational approaches for the 8<sup>th</sup> country programme of assistance and the next UNDAF cycle;
- (iv) To feed data and findings into the clustered country programme evaluation of UNFPA engagement in highly-vulnerable contexts.

The *intended audience* are UNFPA (at country, regional and global level) and the UNFPA Executive Board. Additionally, counterparts within the Government of Nepal (GoN) and other development partners are expected to benefit from evaluation results. The subject of the CPE are all interventions under the UNFPA Nepal Country Programme Action Plan (CPAP) 2013-17 implemented between January 2013 and September 2016.

### The UNFPA Nepal Country Programme 2013-17

According to UNFPA's Business Model, Nepal is classified as "red" because of its high needs and inability to finance. The initial proposed indicative commitment was \$30.5m, covering SRH (\$12.2m); population dynamics (\$8.9m); and gender equality (\$8.2m). An amount of \$1.2m was allocated to programme coordination and assistance. However, Regular Resources (RR) annual spending ceilings have dropped significantly from \$4.6m in 2014 to 4.05m and 3.43m in 2016. The importance of Other Resources (OR) has therefore grown and the CO has increasingly been rewarded for its resource mobilization efforts. CP7 was implemented with the support of over 40 Implementing Partners, including 18 district authorities. The CPD 2013-17 was approved by the UNFPA Executive Board in 2012 and operationalized through a CPAP. During the previous country programme, UNFPA had expanded its coverage from six to 18 districts that were making slow progress in achieving ICPD goals in three geographic clusters. UNFPA's local representation is through District Programme Officers and three Regional Support Offices. The earthquake in April 2015 led to a temporary shift in priorities and resources to 14 severely-affected districts. CP7 pursues three outcomes:

- Outcome 1: Improved access to SRH services and sexuality education
- Outcome 2: Gender equality and reproductive rights advanced
- Outcome 3: Population dynamics and its interlinkages with the needs of young people, SRH (including family planning), gender equality and poverty reduction addressed

Outcome 1 consists of supply-side interventions in maternal health and family planning with a particular focus on adolescent SRH; it also builds on behaviour change and demand creation. Outcome 2 is very strongly focused on GBV and child marriage. Outcome 3 supports the generation of data and analyses and their use in policy making and planning; it has a specific component on youth empowerment and participation. Emergency preparedness and response is mainstreamed throughout CP7.

### Methodology

The evaluation process was divided into design, data collection, and analysis and reporting phases, amounting to 200 work days. The CPE was structured around two categories of evaluation criteria: (i) relevance, effectiveness, sustainability and efficiency; and (ii) coordination and added value. Data collection methods included document review; financial data analysis; monitoring data analysis; semi-structured interviews with UNFPA staff,

Implementing Partners, donors and UN agencies in Kathmandu; semi-structured interviews and group discussions with district officials, district service providers and beneficiaries in four purposively selected districts (Baitadi, Sunsari, Sindhuli and Dang); and telephone interviews with officials in two earthquake-affected districts Gorkha and Sindhupalchowk. The evaluation matrix was key for triangulating information and formulating evidence-based findings.

## Main Findings

CP7 is well aligned with relevant *national* legislation, policies, strategies and programmes. Its design under the National Health Sector Programme II and annual planning were a joint effort. CP7 is clearly also an integral part of district development plans. UNFPA was responsive: it adapted CP7 in response to the violent earthquake in April 2015.

Adolescents and youth participated in CP7 design and UNFPA has made a conscious effort to consult and involve them in implementation; they were less systematically represented in annual planning. Deliberate involvement of vulnerable and marginalized women in design and planning has been less.

Nepal's high vulnerability to natural disasters and UNFPA's actual support for emergency response preparedness are insufficiently reflected in the CPAP and its Results and Resources Framework (RRF).

CP7 was logically connected to the Mid-term Review of the UNFPA Strategic Plan 2008-13 and aligns well with the Strategic Plan 2014-17 outcome areas. The re-aligned RRF is a very good reflection of the SP 2014-17 Integrated Results Framework in the area of emergency preparedness and response, but only since the 2015 earthquake. CP7 and the UN Development Assistance Framework are in sync except for the area of emergency response preparedness.

Gender equality is at the centre of CP7. UNFPA has made a point to engage men and boys and other likely gatekeepers; it has applied a rights-based approach, at programme and policy levels. UNFPA has clearly targeted vulnerable women and girls of reproductive age, most prominently GBV survivors and women at risk of being married early. It has not targeted the specific needs of very young adolescents (10-14) who are a corporate strategic priority.

UNFPA has influenced major policies, strategies and standards. The Constitution and the National Population Policy are two highlights. UNFPA also contributed to instituting a human rights-based approach to family planning; it can claim credit for important developments in midwifery, obstetric fistula, ASRH, CSE and youth development. UNFPA's contribution to the legal, policy and programme framework regarding GBV and ending child marriage is evident - e.g., Clinical Protocol on GBV, National Strategy on Ending Child Marriage and "Rupantaran".

With UNFPA contribution, selected clinical training institutions have started to provide competency-based training to improve family planning services and reduce reproductive health morbidities. Use of the UNFPA-supported LMIS for monitoring stock-outs has increased, but the system is not fully operational, and is already being revamped. UNFPA played a positive role, but factors such as natural disasters and restrictions on mobility need to be considered. Implant stock-outs seem to have been an issue. UNFPA has contributed to successful interventions to provide services for vulnerable women from low CPR pockets and suffering from obstetric fistula. Together with partners, it can claim credit for the very recent introduction of midwifery education. FP micro-planning and satellite clinics are considered an effective approach.

Thanks to collaboration between UNFPA and the government, more and more health service providers are being trained on ASRH at six government-certified clinical training sites. Training sites are providing competency-based ASRH trainings based on a revised and clearly relevant training package. UNFPA also played a crucial role in revisiting the quality criteria and certification process for AFHS centres. Already 24 health facilities in ten UNFPA priority districts are certified AFHS centres, thanks to UNFPA, and others are in the pipeline. Making available a dedicated consultation room that ensures privacy is a problem. The number of adolescents utilizing the AFHS has increased, but coverage remains low. Recording, reporting and analysis of ASRH service utilization data is a bottleneck to effective planning, monitoring

and decision-making. The revised HMIS does not separately capture ASRH services; it only offers data for the broad age cohort 15-49.

UNFPA is on track to strengthen the inclusion of CSE topics in grades 1 to 10. However, subordinate to formal curriculum review cycles, it will not completely be able to achieve its objectives. UNFPA is also supporting the Ministry of Education to include CSE teacher training in its in-service training programme. UNFPA facilitated policy recommendations for improving CSE for *out-of-school* adolescents and youth. Plans are in the making for targeting their specific information and education needs.

UNFPA has moved away from somewhat scattered IEC/BCC activities to a programmatic approach that promises greater effectiveness.

UNFPA has contributed to better quality public health services for GBV survivors, but so far mainly only in six districts. It has also provided limited support for safe houses, but those observed faced problems. Data collected with UNFPA support through the GBV Information Management System, while not comprehensive or representative, are expected to be a powerful advocacy tool.

UNFPA has been prominently involved in preventing child marriage through local-level mechanisms; less so to reduce other discriminatory and harmful practises. UNFPA has successfully used “Rupantaran” to empower adolescent girls to speak out to their peers and elders against violence and child marriage. UNFPA outreach has had an immediate effect on the attitudes of targeted men and boys towards VAW; however, it is doubtful that UNFPA has influenced male attitudes on a larger scale.

UNFPA facilitated further dissemination of 2011 census results through three Population Monographs. It enabled the Central Bureau of Statistics and the Ministry of Health to conduct and publish national-level surveys and analyses, including further analysis of the 2011 DHS. Progress in setting up new databases has been modest. The web-based CensusInfo is new, but not well known. More government agencies are implementing programmes that respond to population, SRH, youth and/or GE. However, not all were influenced by UNFPA. Despite UNFPA’s efforts, the percentage of national budget allocated for population, SRH, youth and GE declined considerably from 10.5% in FY 2012-13 to 3.1% in 2015-16 instead of increasing to the targeted 15%. On the other hand, the percentage of budget allocations has increased considerably across UNFPA’s priority districts, with UNFPA contribution. The number of districts using UNFPA-supported census and national surveys in their *planning* processes has increased considerably, but is still rather low. Moreover, use is only partial. Neither have authorities in UNFPA priority districts *reported* on ICPD indicators in a comprehensive manner. Collaboration with youth-led NGOs and the Ministry of Youth and Sports has facilitated participation of youth in central-level policy making and planning. UNFPA has also organized youth in its priority districts. Mainly male youth are increasingly vocal in district development processes through youth network members. Contrary to original intentions, UNFPA has not worked with vulnerable women in an organized manner similar to youth networks.

UNFPA contributed to the National Disaster Response Framework. It has been playing a lead role in emergency preparedness in the areas of RH and GBV, within the cluster system and the Humanitarian Country Team. More UNFPA priority districts have incorporated MISP in their Disaster Response Plans, including thanks to UNFPA. UNFPA has also contributed to district-level cluster *coordination* in health and protection. It has been part of joint efforts to scale up prepositioned dignity kits and has prepositioned RH kits.

UNFPA participated in the Post-Disaster Needs Assessment, which influenced the official earthquake response. UNFPA successfully led the RH and GBV sub-clusters. It was a key actor for providing post-disaster A/SRH services and information. A considerable number of vulnerable women and girls were reached, including through mobile RH camps. UNFPA’s support for protecting women and girls went beyond support for the health system. Although some open questions remain in view of future emergencies, female-friendly spaces and dignity kits were much appreciated.

UNFPA applies a risk-based approach to financial management. UNFPA Implementing Partners have received funds in a timely manner. Despite difficult circumstances and uncoordinated fiscal years, implementation has been high – 92.2%. UNFPA Nepal has complied with corporate policies, guidance, rules and regulations. In some instances, it has helped create and improve them and has successfully lobbied for their adaptation.

Resource mobilization has become increasingly important in view of plunging annual RR spending ceilings. UNFPA has mobilized considerable OR from a broad range of sources, including UNFPA Trust Funds, particularly for SRH and GE. CP7 has been delivered with an insufficient number of fixed-term staff and unsatisfactory staffing levels. Additional human resource capacities for implementing and monitoring projects have had to rely on external funding. The placement of UNFPA District Programme Officers is clearly a meaningful and advantageous investment.

Decentralized programming has its benefits, but UNFPA may have interpreted its focus on 18 priority districts too rigidly. Looking ahead, UNFPA might consider downscaling before definitively exiting priority districts. Future decentralized programming will have to align with local-level reforms and restructuring; it should be more focused on greatest needs.

Monitoring is a regular feature of CP7 implementation, especially at the activities and output level. For lack of district-level data, the RRF is often not a good basis for results-oriented planning, monitoring and reporting at the outcome level. UNFPA humanitarian programming in the earthquake-affected districts had a dedicated and functioning results-based monitoring and reporting system.

UNFPA Nepal humanitarian preparedness plans for the CO and the three Regional Support Offices are available and up-to-date. With some important exceptions related to emergency operations planning, staff capacities, procurement, and information management, UNFPA Nepal fares well on the Minimum Preparedness Actions Dashboard.

UNFPA has been an active leader and contributor to UNCT coordination mechanisms. Evidence revealed a number of good examples of joint programming and joint programmes, above all in the areas of child marriage, GBV and adolescent health. Examples of factors contributing to successful relationships are credibility; trust and mutual understanding; common issues/interests; and capable staff. National and international partners alike voiced positive opinions on UNFPA's added value.

## Conclusions

*Conclusions have been made against the background of plunging Regular Resources and no improvements in the staffing situation. They also assume continued high levels of political instability and vulnerability to natural disasters. They are based on the assumption that state restructuring will remain delayed. This Executive Summary lists strategic conclusions and recommendations.*

The GoN has a constitutional commitment to federalise Nepal. However, the timeframe and roadmap for the reforms and especially the future of the current 75 districts under the new federal provinces have not yet been established. Reforms will require changes to UNFPA's organizational structure and to the way it has been co-operating with its government counterparts, especially at the local level; they will generate a need for new datasets and analyses as well as for institutional capacity building. *UNFPA needs to anticipate changes in the state structures.*

UNFPA has invested a lot in data generation and databases, but the availability of up-to-date and adequately-disaggregated data is still a challenge, *especially for the sub-national level.* This will affect GoN and UNFPA priority-setting, planning, monitoring, trends analysis and projections. *More needs to be done to bridge the data gap.*

CP7 was not realigned to target the specific needs of very young adolescents (10-14), a UNFPA corporate priority and highlighted in the National Plan of Action on the Holistic Development of Adolescents. *Special efforts should be considered to ensure that very young adolescents benefit.*

UNFPA has been an active humanitarian actor. However, this important work was insufficiently reflected in the CPD or CPAP 2013-17 and not reported and accounted for, also because the SP 2014-17 IRF is only a partial reflection of what UNFPA contributes. *UNFPA should be more explicit on its types of and expected contributions to emergency preparedness.*

UNFPA's regional and district presence allows for focus and synergies; it generates concrete local experience for feeding into national policy dialogue and systems strengthening. However, after having increased the number of programme districts from six to 12 to 18, the UNFPA Nepal CO is rightly reconsidering its decentralized programming modality. *UNFPA should reduce its number of priority districts and concentrate more.*

Youth participation in political processes has increased, also thanks to UNFPA. However, it is not clear what UNFPA support to strengthen youth participation has resulted in and to what extent it has drawn attention to and investments in SRH. *The UNFPA CO should be clearer on its expectations of adolescents and youth participation and the outcome of its efforts.*

An important challenge has been identified concerning the selection of and level at which to pitch RRF outcome indicators. The current practise to pitch some at national level and others at the level of the 18 priority districts is unsatisfactory. While in most cases UNFPA contribution is most likely and easier to establish at district level, data on a range of topics have been unevenly available. However, in a country like Nepal, and with the CO's limited resources, the gap between UNFPA outputs and national outcomes is often (too) big. *Outcome-level monitoring should be strengthened.*

## Strategic Recommendations

- In view of uncertainties around state restructuring, UNFPA CO senior management should initiate an internal scenario planning process.
- The PD component of CP8 should prioritize support for the 2021 Population and Housing Census.
- The UNFPA CO should explore options for advancing analysis and use of CRVS-generated vital statistics in local planning and decision-making.
- The UNFPA CO should advocate with the MoH and provide technical support, including training at all levels, for incorporating disaggregated ASRH indicators and data in the government reporting system.
- UNFPA Nepal CO should commission/use analyses and explore opportunities to strengthen the participation and targeting of very young adolescents (10-14).
- The clustered country programme evaluation of UNFPA's engagement in highly-vulnerable situations should review emergency-related IRF indicators.
- UNFPA Nepal senior management should ensure that the CPD and CPAP 2018-22 speak more to Nepal's vulnerability and that the RRF better reflects outputs that are expected to contribute to improved emergency preparedness.
- UNFPA CO senior management should review priority districts against ICPD goals and plan its complete or partial exit from individual districts. UNFPA should be more open to selective programming in other disadvantaged districts pending available OR, but not contract further DDCs.
- CP8 should be more clearly targeted towards and track the contribution of its support for adolescent and youth participation to advancing UNFPA's mandate and ICPD priorities.
- CP8 RRF outcome indicators should be located at the national or district-level depending on the scale of UNFPA's assistance and data availability. While the contribution of a wider group of partners is usually essential, outcomes need to be seen as having a significant and credible relationship with UNFPA outputs.

## Chapter 1: Introduction

*This chapter provides introductory information for the reader to understand the purpose and objectives (Section 1.1) of the Nepal country programme evaluation (CPE), its scope (Section 1.2), and the structure of the present report (Section 1.3).*

### 1.1 Purpose and objectives of the country programme evaluation

In July 2016, the UNFPA Nepal country office (CO) commissioned an external evaluation of its 7<sup>th</sup> country programme (CP7) of assistance to the Government of Nepal 2013-17 as per the 2013 UNFPA Evaluation Policy and the UNFPA Transitional Biennial Budgeted Evaluation Plan 2014-15.<sup>4</sup> The CPE assesses how UNFPA contributed to improving sexual and reproductive health (SRH) and gender equality (GE), and how it addressed population dynamics (PD) in Nepal. The Nepal CPE was selected for the clustered country programme evaluation (CCPE) of UNFPA engagement in highly-vulnerable contexts, led by the UNFPA Evaluation Office. It thus also assesses the effectiveness of UNFPA's humanitarian preparedness planning and response.<sup>5</sup>

The *purpose* of the CPE is threefold: Evaluation results are intended to demonstrate accountability. They are meant to support evidence-based decision taking, particularly in view of formulating the 8<sup>th</sup> UNFPA country programme. And they should contribute to UNFPA's knowledge base. The *specific objectives* of the CPE are:

- (v) To evaluate the programmatic results of CP7 as well as UNFPA's strategic positioning in Nepal;
- (vi) To draw lessons on the relevance and performance of UNFPA-supported interventions in the areas of SRH, young people's needs, gender equality and population dynamics;
- (vii) To propose a set of recommendations with regard to programming strategies and operational approaches for the 8<sup>th</sup> country programme of assistance and the next UNDAF cycle;
- (viii) To feed data and findings into the clustered country programme evaluation of UNFPA engagement in highly-vulnerable contexts.

The *intended primary users* of the evaluation are UNFPA (at country, regional and global level) and the UNFPA Executive Board. Additionally, counterparts within the Government of Nepal (GoN) and other development partners are expected to benefit from evaluation results.

### 1.2 Scope of the country programme evaluation

The subject of the CPE is the UNFPA Nepal country programme action plan (CPAP) 2013-17, whose Results and Resources Framework (RRF) was re-aligned with the UNFPA Strategic Plan (SP) 2014-17 Integrated Results Framework (IRF), and further aligned following the violent earthquake on April 25<sup>th</sup> 2015.<sup>6</sup> The evaluation covers all interventions planned or implemented by UNFPA and its Implementing Partners at central level and in the 18 focus districts<sup>7</sup> within the four areas of the organization's SP 2014-17: (i) sexual and reproductive health; (ii) gender; (iii) population dynamics; and (iv) adolescents and youth. Additionally, it focuses on UNFPA's response to the April 2015 earthquake in the 14 most-affected districts.<sup>8</sup> The evaluation team was not required to pay equal attention to other instances of emergency situations throughout CP7 such as civil disturbances, floods or landslides.

The evaluation covers the period between the beginning of the CPAP in January 2013 and the three-week field mission in August/September 2016. Some factual information on finances and

<sup>4</sup> DP/FPA/2013/5 and DP/FPA/2014/2.

<sup>5</sup> Due to its larger than normal scope, the CPE report exceeds the number of pages suggested by the Handbook.

<sup>6</sup> See "Results and Resources Framework (RRF) for Nepal (aligned with new UNFPA Strategic Plan 2014-2017) (aligned with 2015 earthquake)".

<sup>7</sup> The 18 districts for UNFPA regular programming are: Achham, Arghakhanchi, Baitadi, Bajhang, Bajura, Dadeldhura, Dang, Kapilvastu, Mahottari, Pyuthan, Rautahat, Rolpa, Rukum, Saptari, Sarlahi, Sindhuli, Sunsari, and Udayapur. Kanchanpur and Surkhet were districts from the previous CP cycle but had some activities carried over to the first half of 2013. They are excluded from this evaluation.

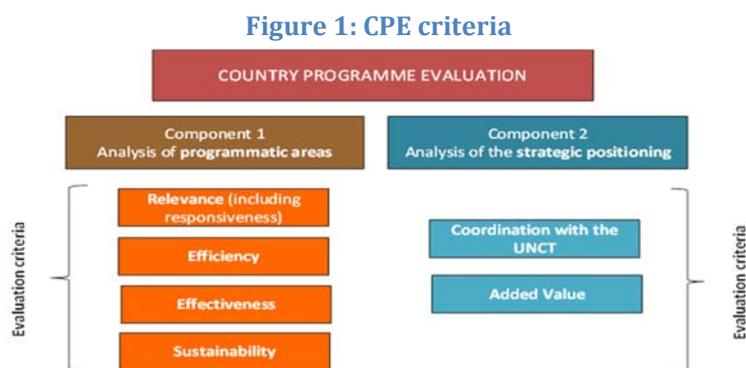
<sup>8</sup> 14 emergency-affected districts for UNFPA humanitarian programming were: Bhaktapur, Dhading, Dolakha, Gorkha, Kabhrepalanchok, Kathmandu, Lalitpur, Makawanpur, Nuwakot, Okhaldhunga, Ramechhap, Rasuwa, Sindhuli and Sindhupalchok. Only one of UNFPA's regular districts was also earthquake-affected – i.e., Sindhuli.

donors as per November 2016 was included during the reporting phase. The evaluation was therefore not able to assess final achievements. Each programme component (CP7 outcome area) was evaluated based on the OECD/DAC criteria relevance, effectiveness, sustainability and efficiency. In addition, CP7 was also assessed against the two criteria UNCT (UN country team) coordination and added value as per the UNFPA CPE Handbook.

### 1.3 Evaluation methodology and process

#### 1.3.1 Evaluation criteria and evaluation questions

This CPE has two standard components: (i) analysis of UNFPA programmatic areas; and (ii) analysis of UNFPA’s strategic positioning. The UNFPA CPE Handbook prescribes the set of evaluation criteria for each of these two components (Figure 1). The analysis of UNFPA programmatic areas is conducted along four standard OECD-DAC evaluation criteria: relevance, efficiency, effectiveness and sustainability. The two criteria applied to the analysis of UNFPA’s strategic positioning are coordination with the UNCT<sup>9</sup> and the added value of UNFPA<sup>10</sup>.



Source: UNFPA CPE Handbook

While evaluation criteria encompass a wide range of aspects and features, evaluation questions (EQs) are used to focus the evaluation on specific aspects, enabling the evaluation team to focus on a limited number of key points. Establishing a set of EQs allows for more targeted data collection, a more concentrated and in-depth analysis and a more focused and useful evaluation report. The CPE Handbook recommends selecting eight to ten evaluation questions. During the preparatory phase, UNFPA included 19 EQs in the CPE Nepal ToR (Annex 1). From those 19 questions the evaluation team was meant to distil not more than ten.<sup>11</sup> The evaluation team thus further refined the EQs, in consultation with UNFPA and the ERG, and considering the approach paper for the clustered country programme evaluation of UNFPA engagement in highly-vulnerable contexts (CCPE). Table 1 sets out the nine EQs that guided data collection and analysis. Table 2 gives an overview of how the EQs relate to the evaluation criteria.

**Table 1: CPE Nepal Evaluation Questions**

Component 1: Analysis of programmatic areas
<b>EQ1 [alignment]:</b> To what extent was CP7 design, planning and implementation: (1) aligned with government priorities; (2) consistent with the needs of the population, in particular young people and marginalized/vulnerable groups; and (3) aligned to relevant UN system and UNFPA policies and strategies?
<b>EQ2 [vulnerability]:</b> How did UNFPA take into account the country’s vulnerability to disasters and emergencies in planning and implementing its interventions?
<b>EQ3 [SRH services/information and CSE]:</b> To what extent has UNFPA contributed to sustainably improving the availability of and use of quality comprehensive SRH services, in particular for and by young people and

<sup>9</sup> Coordination within the UNCT is defined as the extent to which UNFPA has been an active member of, and contributor to, existing coordination mechanisms of the United Nations country team.

<sup>10</sup> Added value is defined as the extent to which the UNFPA country programme adds benefits to what would have resulted from other development actors’ interventions only.

<sup>11</sup> CPE Nepal Terms of Reference, p5.

vulnerable/marginalized women? To what extent has UNFPA contributed to increased availability of CSE and SRH/HIV information to promote utilization of SRH services?
<b>EQ4 [GBV services and harmful practices]:</b> To what extent has UNFPA contributed to improving the availability of and access to quality GBV services in a sustainable manner? To what extent has it contributed to preventing GBV, child marriages and other discriminating and harmful practices?
<b>EQ5 [policies &amp; planning]:</b> To what extent has UNFPA sustainably contributed to a stronger emphasis of national and sub-national policies, plans and budgets on population, SRH, youth and GBV issues in an evidence-based and participatory manner, informed by population dynamics?
<b>EQ6 (emergency preparedness &amp; response):</b> To what extent was (is) UNFPA, along with its partners, likely and able to respond to crises?
<b>EQ7 [financial &amp; human resources]:</b> To what extent has UNFPA made good use of human and financial resources to pursue the achievement of CP7 outputs and outcomes?
<b>Component 2: Analysis of strategic positioning</b>
<b>EQ8 [UNCT coordination]:</b> To what extent has UNFPA contributed to the functioning and consolidation of UNCT coordination mechanisms?
<b>EQ9 [UNFPA added value]:</b> To what extent has UNFPA made good use of its comparative strengths?

**Table 2: Relationship between EQs and Evaluation Criteria**

	Relevance	Effectiveness	Efficiency	Sustainability	Coordination	Added Value
EQ1	x					
EQ2	x					
EQ3		x		x		
EQ4		x		x		
EQ5		x		x		
EQ6		x				
EQ7			x			
EQ8					x	
EQ9						x

As required, an evaluation matrix (Annex 2) was prepared. The matrix displays the core elements of the evaluation: (a) *what* will be evaluated (evaluation criteria, evaluation questions and related issues to be examined - i.e., “assumptions to be assessed” and qualitative/quantitative indicators); and (b) *how* to evaluate (sources of information and data collection methods). Evaluation questions, assumptions for assessment and indicators are closely linked to the CP7 logic through the CPAP RRF, including earthquake-related indicators.<sup>12</sup>

### 1.3.2 Methods for data collection and analysis

The collection of evaluation data was carried out through a variety of methods:

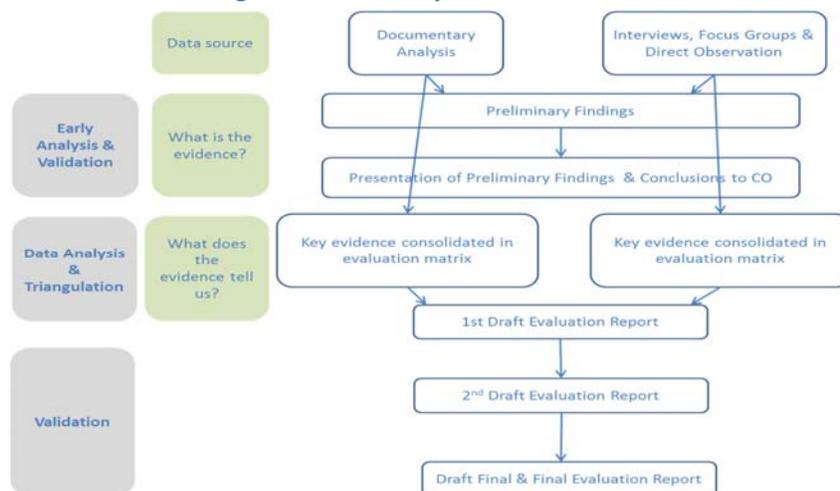
- Analysis of documents and websites (Annex 3)
- Analysis of financial data (Annex 4)
- Analysis of CO monitoring information (Annex 10)
- Briefing(s) from and discussions with UNFPA CO staff members
- Semi-structured interviews with representatives of UNFPA Implementing Partners;
- Semi-structured interviews with representatives of selected other partners and stakeholders
- Semi-structured interviews with CP7 donors
- Interviews and focus group discussions with beneficiaries at institutional and community levels
- Direct observation of UNFPA-targeted institutions and areas

Interviews were conducted with the help of interview guides (Annex 5). Interview logs were kept by each evaluator. The evaluation matrix template was used to consolidate key data and information assembled from the different strands of data collection efforts.

<sup>12</sup> Footnotes in the evaluation matrix indicate specific linkages.

Team members closely adhered to the UNEG Ethical Guidelines for Evaluation and the UN Code of Conduct for Evaluations in the UN System.<sup>13</sup> All interviewees were assured of confidentiality. Data analysis (Figure 2) built on triangulating information obtained through interviews, focus group discussions, document analysis and direct observation along the lines of the assumptions for assessment and indicators. To the extent possible, available and relevant, data were considered disaggregated at the level of gender, age and districts. The consolidated information was the starting point for triangulation and arriving at evidence-based evaluation findings and subsequently formulating conclusions as a basis for recommendations.

**Figure 2: Data Analysis and Validation**



### 1.3.3 Stakeholder and district sampling

Stakeholder maps were developed by the CO for each programmatic area (Annex 6). They formed the basis for selecting the sample of stakeholders and beneficiaries to be met during the data collection phase in the capital city Kathmandu and sample districts. Annex 7 provides detailed information about persons consulted. According to the CPE Handbook “the evaluators should not aim at obtaining a statistically representative sample, but rather an illustrative sample”. In Kathmandu, priority was given to interviewing UNFPA staff, UNFPA Implementing Partners, UN agencies familiar with CP7 and CP7 donors. Table 3 indicates the number of people met along different types of stakeholders; Table 4 along the main topics covered.

**Table 3: Number of Kathmandu-based Stakeholders Consulted**

UNFPA staff	GoN IPs	NGO IPs	UN entities	CP7 donors	Others
17 PAX	14 PAX from 11 IPs	18 PAX from 13 IPs	8 PAX from 5 entities	2 PAX from 2 donors	13 PAX from 11 other organizations

**Table 4: Number of Meetings along Key Topics**

SRH	ASRH	GE	PD	Emergency
18	11	16	10	12

District-level itineraries were the same with some adaptations to allow for district-level specificities and depending on feasibility and availabilities. Priority was given to meeting UNFPA RSO staff and District Programme Officers as well as District Disaster Relief Committee (DDRC) members and District Development Committee (DDC), District Health Office (DHO), Women and Children Office (WCO) and District Education Office (DEO) officials. To the extent

<sup>13</sup> <http://www.unevaluation.org/document/detail/102> and <http://www.unevaluation.org/document/detail/100>.

possible, team members also met with health service providers, teachers, women cooperative members and end beneficiaries, including adolescent girls, mothers, parents, men and boys.

The universe of districts covered was UNFPA's 18 priority districts where UNFPA's regular programme is being implemented, as well as the 14 severely earthquake-affected districts. In each district, UNFPA implements "mini-UNFPA programmes" covering all three programmatic areas. Only one of UNFPA's priority districts was earthquake-affected – i.e., Sindhuli. According to the CPE ToR, the evaluation team, in collaboration with the UNFPA CO, was expected to select 3-6 districts for field visits. The sample of districts to visit was made on the basis of criteria agreed upon with the UNFPA CO and the Evaluation Reference Group (ERG) – i.e.

- Be illustrative of all programmatic areas
- Be illustrative of especially financially-large and financially-modest investments
- Ensure an illustrative coverage of UNFPA's working districts and geographic inequalities and variations by reflecting the five development regions and the three eco-development regions of Nepal
- Cover at least one district from each of UNFPA's three regional clusters where UNFPA has a regional support office (RSO)
- Cover districts from different expansion periods (2004, 2010, 2011)
- Cover at least one earthquake-affected district
- Allow a demonstration of successes and challenges
- Logistical feasibility and security considerations

Of the 18 UNFPA-supported districts, the CO considered eight districts ineligible for site visits: a number of districts in the Central and Eastern regions were and still are considerably affected by strikes and government staff changes, affecting UNFPA activities and potentially the evaluation team's mobility. Others in the Mid- and Far-western regions are difficult to access. In others, UNFPA has made comparatively very low investments. Of the ten remaining districts, the evaluation team submitted a preliminary proposal to visit Baitadi, Dang, Sindhuli and Sunsari, recognising that further planning would show what is possible, and whether to give more weight to assessing less districts comprehensively or more districts partially. At the outset of the data collection phase, the team and UNFPA CO confirmed the four districts, acknowledging that covering them all would not be possible within the given timeframe and thus adding additional days for the national consultants to cover Dang after the departure of the international team leader. In addition, ERG members suggested adding an earthquake-affected district where UNFPA had no prior presence, contrary to Sindhuli. The decision was taken to cover Gorkha and Sindupalchowk where UNFPA had "hubs" during the earthquake response. Interviews with concerned DHO and WCO officials were conducted by phone.<sup>14</sup>

### 1.3.4 Limitations

The evaluation team encountered some limitations, which were mitigated as best as possible.

- *Time restrictions:* The design report warned that the standard three-week field mission is short for a programme as complex as Nepal that is implemented with over 40 Implementing Partners in Kathmandu, requiring the evaluation team to spend a good week in the capital. In addition, the data collection mission to Baitadi in the Far-west absorbed five days. The team was therefore only able to travel together to three districts. Dang was covered after the departure of the team leader. An additional five days were added to the consultants' contracts to mitigate workload implications.
- *Limited coverage of earthquake response:* It was not possible to cover UNFPA's earthquake response in-depth. Only one affected district (Sindhuli) was visited. To mitigate this limitation, telephone interviews were conducted with the DHOs and WCOs in Gorkha and Sindupalchowk.
- *Absences:* One evaluator was not given leave of absence from his employer to join the district-level data gathering. To mitigate this limitation, PD-related interviews were conducted by telephone.
- *Stakeholder unavailability:* Numerous stakeholders in Kathmandu were not available at a time convenient to them and the evaluation team, most importantly from the Family Health Division (FHD) of the MoH. For lack of time, it was not possible to rectify this omission later on in the evaluation process. To the extent possible, the evaluation team bridged this gap with document analysis.

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<sup>14</sup> See CPE Design Report for further details on district sampling.

- *Data gaps:* The design phase concluded that data availability and reliability was of sufficient quality to facilitate a credible evaluation of CP7. During the analysis and reporting phase, the evaluation team realized that an assessment of UNFPA's contribution to national-level progress was not always possible due to missing data for the period under investigation and the 18 priority districts for higher-level (outcome) results.
- *Language constraints:* Especially district-level stakeholders and beneficiaries did not speak or understand English. To mitigate the absence of an interpreter, national evaluators agreed to interpret for the international team leader, however, this was not always possible in an optimal manner.

### 1.3.5 Evaluation process

As outlined in the CPE Handbook and the CPE Nepal ToR (Annex 1), the evaluation process was divided into three phases: design, data collection, and analysis and reporting.<sup>15</sup> Table 5 lists the associated activities, outputs and number of work days.

**Table 5: CPE Activities, Outputs and Work Days**

Design Phase (July-August 2016)		
Activities	Outputs	Work Days
Home-based desk review	<ul style="list-style-type: none"> <li>• Stakeholder mapping and sampling</li> <li>• District sampling</li> <li>• List of Atlas projects</li> <li>• Collection of latest monitoring data</li> <li>• Financial analysis</li> <li>• CP7 effects diagrams</li> <li>• Evaluation matrix</li> <li>• CPE field visit work plan</li> <li>• Draft design report</li> </ul>	45
Consultations with UNFPA CO and EO		
Draft design report		
Finalize design report in consultation with UNFPA CO, APRO, EO and ERG		
Data Collection Phase (August-September 2016)		
ERG briefing	<ul style="list-style-type: none"> <li>• Final design report</li> <li>• Interview logs</li> <li>• List of persons met</li> <li>• Updated CPE field visit work plan</li> <li>• Presentation of preliminary findings</li> </ul>	85
Finalize design report		
Conduct data gathering		
Compile key information from different strands of data collection in evaluation matrix		
Present preliminary findings and conclusions to UNFPA CO, APRO and ERG		
Analysis and Reporting Phase (September-December 2016)		
Conduct any missing data collection	<ul style="list-style-type: none"> <li>• Completed evaluation matrix</li> <li>• 1<sup>st</sup> and 2<sup>nd</sup> draft evaluation reports</li> <li>• Draft final and final evaluation reports</li> </ul>	70
Analyse data		
Draft 1 <sup>st</sup> draft final evaluation report		
Draft 2 <sup>nd</sup> draft final evaluation report		
Finalize and submit draft final evaluation report		
Submit final evaluation report		

The CPE was an external, independent exercise undertaken by four independent evaluators, in close cooperation with the UNFPA CO and under the overall guidance of the UNFPA Asia and Pacific Regional Office and UNFPA Evaluation Office. The UNFPA Deputy Representative was UNFPA's Evaluation Manager and main point of contact for the evaluation team and the ERG. The evaluation team was supported in its day-to-day work by the UNFPA CO M&E Officer.

An Evaluation Reference Group (ERG) was constituted by UNFPA to provide oversight and to ensure the overall quality of the evaluation process and products. It was composed of representatives from the Ministry of Finance (MoF), National Planning Commission (NPC), UNDAF M&E Group, IPs and selected UNFPA staff. A UN Youth Advisory Panel (UNYAP) representative was also included.

<sup>15</sup> The CPE ToR did not envisage an in-country scoping mission.

## Chapter 2: Country Context

*This part of the evaluation report provides background information for the reader to understand the country context in which UNFPA has worked in Nepal.*

### 2.1 Development challenges and national responses

#### 2.1.1 Political and socio-economic context

The Federal Democratic Republic of Nepal is a land-locked least developed country. Nepal has tremendous geographic diversity. From South to North, it can be divided into three eco-system regions: Terai, Hill and Mountain. Nepal is characterized by slow economic growth and a low level of human development. Its development stage stems from a politically and socially-fragile post-conflict situation, weak governance structures, poverty, deeply-entrenched forms of social exclusion, and high vulnerability to natural disasters. The economy has been severely impacted: From fiscal year (FY) 2012-13 to FY 2014-15, GDP growth dwindled at around 3-5% per year. For 2016 the preliminary growth estimate is at 0.7%.<sup>16</sup> Unemployment was 2.1% in 2008.<sup>17</sup>

After the popular People's Movement II of 2006 and the Constituent Assembly elections of 2008 and 2013, a political system of a secular democratic republic state was enshrined in Nepal's new constitution, which came into effect as recently as September 20<sup>th</sup> 2015, replacing the Interim Constitution of 2007. However, immediately following the promulgation of the constitution, tension and unrest broke out in the Terai in the Southern part of the country resulting in border restrictions and severely limiting the availability of fuel and other necessities such as medicines and earthquake relief material coming through and from India. Widespread protests and strikes forced UNFPA operations in at least six programme districts<sup>18</sup> to close entirely for several months and severely affected the rest of the country. The border restrictions were officially lifted in mid-February 2016. Implementation and monitoring of development programmes have also been affected by the political transition with accompanying socio-political instability. At the district level, the protracted absence of locally-elected bodies has resulted in poor governance of decentralized service delivery and poor public accountability.

#### 2.1.2 Vulnerability

Nepal experienced a decade-long armed conflict, which came to an end on November 21<sup>st</sup> 2006 with the signing of a Comprehensive Peace Agreement. Despite great achievements in building and maintaining peace, the country is still undergoing a complex transition phase. Besides this man-made conflict, UNDP ranks Nepal as the 11<sup>th</sup> most at-risk country for earthquakes and the 30<sup>th</sup> most at-risk for floods.<sup>19</sup> In 2014 a number of districts<sup>20</sup> suffered severe floods. In 2015, the country's development was seriously jolted when, on April 25<sup>th</sup>, a massive 7.8 magnitude earthquake and subsequent aftershocks affected almost a third of the population, killed nearly 9,000 people, injured nearly 23,000 and resulted in more than 700 billion Nepali Rupees (NPR) of damage to human settlements, infrastructure and archaeological sites. Records of past events show that, on average, there are one disaster and two deaths per day.<sup>21</sup>

According to the 2016 INFORM (Index for Risk Management), which UNFPA has used since 2014 for informing the importance of and contextualizing its humanitarian action and emergency preparedness in its programme countries, Nepal faces a high risk of humanitarian crises and disasters occurring, with a very high risk of further natural hazards (physical exposure to earthquakes). Data for the past three years indicate an increasing risk.<sup>22</sup> The

<sup>16</sup> GoN/Ministry of Finance (2016), Economic Survey FY 2015-16.

<sup>17</sup> ILO (2014), Nepal Labour Market Update.

<sup>18</sup> Rautahat, Mahottari, Sarlahi, Sunsari, Saptari in the Eastern development region and Kapilvastu in the Mid-western region. The two RSOs in Dang and Janakpur were also badly affected.

<sup>19</sup> UNDAF 2013-17.

<sup>20</sup> Including Banke, Bardia, Dang and Surkhet. Dang is a UNFPA-supported district.

<sup>21</sup> Nepal Disaster Report 2011.

<sup>22</sup> INFORM Results Report 2016, p3.

Humanitarian Country Team (HCT), including UNFPA, in consultation with the GoN, recently prepared a contingency plan for earthquakes. The worst-case scenario describes a magnitude of 8.6 on the Richter scale with its epicentre in Far-western Nepal generating high-shaking intensities across an area from the Terai to the Himalaya range in the North. Such an earthquake would likely lead to widespread destruction. Possible humanitarian consequences include over 280,000 people likely killed, 3.5m injured and 7.8m displaced.

### 2.1.3 SRH including HIV/AIDS: achievements, challenges and government policies

The 2013 MDG progress report showed a maternal mortality ratio (MMR) of 850 per 100,000 live births in 1990.<sup>23</sup> In order to reduce this high rate, the GoN set an ambitious national target of 213 for 2015. While missing the target, Nepal is on track: the estimated MMR declined to 539 in 1996<sup>24</sup> and 258 in 2015<sup>25</sup>. Similarly, the percentage of women who made the recommended four antenatal visits increased from 14% in 1990 to 59.5% in 2014.<sup>26</sup> However, this suggests that Nepal fell short of its 80% goal by 2015.<sup>27</sup> Moreover, there is a huge gap in use of antenatal care services between urban and rural women: 88% of urban mothers received antenatal care from a skilled provider compared with only 55% of rural mothers. Furthermore, the proportion of women delivering with the help of skilled birth attendants (SBAs) increased nearly eight-fold in the last 25 years from 7% in 1990 to 55.6% in 2014.<sup>28</sup> The large reduction in MMR has been partly attributed to increased use of family planning (FP) services but also by an increase in deliveries by SBAs and Female Community Health Volunteers (FCHVs). The contraceptive prevalence rate (CPR) for modern methods increased from 24% in 1990 to 47.1% in 2014; the total fertility rate decreased from 5.3<sup>29</sup> to 2.3<sup>30</sup> during the same period. However, the unmet need for FP is still 25.2%.<sup>31</sup>

The 2011 Population and Housing Census reported that the adolescent population (10-19 years) accounts for approximately 24% of the total population. This, together with early marriages, has resulted in a high adolescent fertility rate - i.e., 71%.<sup>32</sup> According to other sources, 39% of girls bear their first child by the age of 19.<sup>33</sup> Most of Nepal's public health facilities do not provide specialized SRH services and information to young people. A study undertaken in 2014 on Adolescent-Friendly Health Services (AFHS), initiated by UNFPA jointly with the FHD of the MoH and UNICEF, concluded that adolescents face a number of barriers to accessing AFHS.<sup>34</sup> In 2008, the Ministry of Education (MoE) introduced sexuality education in school curricula, particularly for grades 6 to 10.<sup>35</sup> However, many teachers are reluctant and not adequately trained to run comprehensive sexuality education (CSE) classes. Some basic information such as on modes of HIV transmission and prevention have been included in non-formal education and girls' education curricula.

In Nepal, HIV prevalence in the general population (ages 15-49) is 0.03%, with a prevalence of HIV among people who inject drugs (2.8%-8.3%), men having sex with men and transgender

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<sup>23</sup> NPC/UNDP (2013): Nepal Millennium Development Goals.

<sup>24</sup> NPC (2013): Nepal Millennium Development Goals: Progress Report.

<sup>25</sup> WHO, UNICEF, UNFPA, World Bank Group (2015): Trends in Maternal Mortality: 1990-2015.

<sup>26</sup> NPC (2015): Sustainable Development Goals 2016-2030, National (Preliminary) Report.

<sup>27</sup> NPC (2013): Nepal Millennium Development Goals: Progress Report.

<sup>28</sup> NPC (2015): Sustainable Development Goals 2016-2030, National (Preliminary) Report.

<sup>29</sup> MoH, 1991.

<sup>30</sup> CBS: MICS 2014, Key Findings. Kathmandu: Central Bureau of Statistics and UNICEF Nepal.

<sup>31</sup> CBS, MICS 2014, Key Findings. Kathmandu: Central Bureau of Statistics and UNICEF Nepal.

<sup>32</sup> CBS: MICS 2014, Key Findings. Kathmandu: Central Bureau of Statistics and UNICEF Nepal.

<sup>33</sup> Khatiwada N, Silwal P, Bhadra R, Tamang T. Sexual and reproductive health of adolescents and youth in Nepal: trends and determinants. Further analysis of the 2011 Nepal Demographic and Health Survey. Kathmandu: Population Division, Ministry of Health and Population, GIZ/GFA, Jhpiego, United Nations Population Fund, 2013.

<sup>34</sup> FHD/MoHP, UNFPA Nepal & UNICEF Nepal (2014): Assessing Supply Side Constraints Affecting the Quality of Adolescent Friendly Health Services (AFHS) and the Barriers for Service Utilization.

<sup>35</sup> UNFPA (2014): Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender.

(2.4%), and female sex workers (2%). Only a quarter of adolescents aged 15-24 years have comprehensive knowledge of HIV.<sup>36</sup>

The April 2015 earthquake severely affected health infrastructure in over 40 districts of Nepal. A total of 446 public health facilities were damaged.<sup>37</sup> In the private sector, including non-governmental and community institutions, 16 health facilities were completely destroyed. In the 14 most-severely affected districts, 389 public health facilities were completely destroyed and 403 partly damaged. About 32% of health facilities providing specialized maternal and neonatal services were damaged. UNFPA estimated that 1.4m women of reproductive age were affected, including an estimated 93,000 pregnant women (and up to 10,000 delivering each month).

The GoN has introduced a number of SRH-related laws, policies, strategies and programmes. The central ones are listed in Annex 8.

#### 2.1.4 Population and development: achievements, challenges and government policies

Nepal, like many of the South Asian countries, has been undergoing rapid demographic change. The total population, as of June 2011, was 26.5m with a decadal increase of 14.4% from 2001 (23.2m). The average annual growth rate of the population from 2001 to 2011 was 1.35%, a sharp decline from the 2.25% of the previous decade 1991-2001. The decline is attributed to a decline in fertility and an increasing trend of youth emigration. In 2011 the percentage of female population was slightly higher (51.5%) than male (48.5%) with a sex ratio of 94.2 men per 100 women. Broadly by age groups, nearly 35% of the population was below 15 years, 57% was in the working-age group of 15-59 years and 8% was 60 years old and above. According to the UN definition (Box 1), the youth population aged 15-24 was 20% in 2011. The National Youth Policy, however, defines youth as “women, men and third gender” persons aged 16-40 years old. Based on this definition, the youth population in Nepal in 2011 was close to 40%.

##### Box 1: Adolescents and Youth Definition

The United Nations understands adolescents to include persons aged 10 to 19 years and youth as those between 15 and 24 years for statistical purposes without prejudice to other definitions by Member States. Together, adolescents and youth are referred to as young people, encompassing the ages of 10 to 24 years.<sup>38</sup> In addition, distinctions are sometimes made between the age groups of the very young adolescents (10-14) and the slightly older ones (15-19). Nepal’s 2015 National Youth Policy defines youth as “citizens aged 16 to 40 years old. The Youth Vision 2025 of Nepal also adopted the same definition but divided youth into two groups: youth aged 16-24 (to be targeted for education, health, trainings, leadership development and employment) and youth aged 25-40 (to be targeted for employment, leadership development, management development, youth investment, policy formulation and implementation)<sup>39,40</sup>. Various GoN policies define adolescents as 10 to 19 years.

The 2011 census clearly indicated a shifting trend of the population. The pyramid base (Figure 3) is shrinking, resulting in a youth bulge and opening a window of opportunity for demographic dividend for the next two to four decades. Ageing is expected to set in after 2050. Life expectancy at birth increased from about 41 in the early 1970s to 67 in 2011. Such a significant change in life expectancy was due to increasingly modern health facilities that reduced death rates, especially infant and child death rates, especially during recent years. The country saw a rapid fall in the infant mortality rate, from about 117 per 1,000 live births in the 1980s to about 41 in 2011.<sup>41</sup> The target of the current 13<sup>th</sup> Plan (2013/14-2015/16) is to achieve an increase in life expectancy at birth to 71 years.<sup>42</sup>

<sup>36</sup> NCASC (2015): EPI Fact Sheet.

<sup>37</sup> NPC (2015): Nepal earthquake 2015: Post Disaster Needs Assessment Vol. B: sector reports.

<sup>38</sup> <https://www.unfpa.org/sites/default/files/resource-pdf/One%20pager%20on%20youth%20demographics%20GF.pdf>.

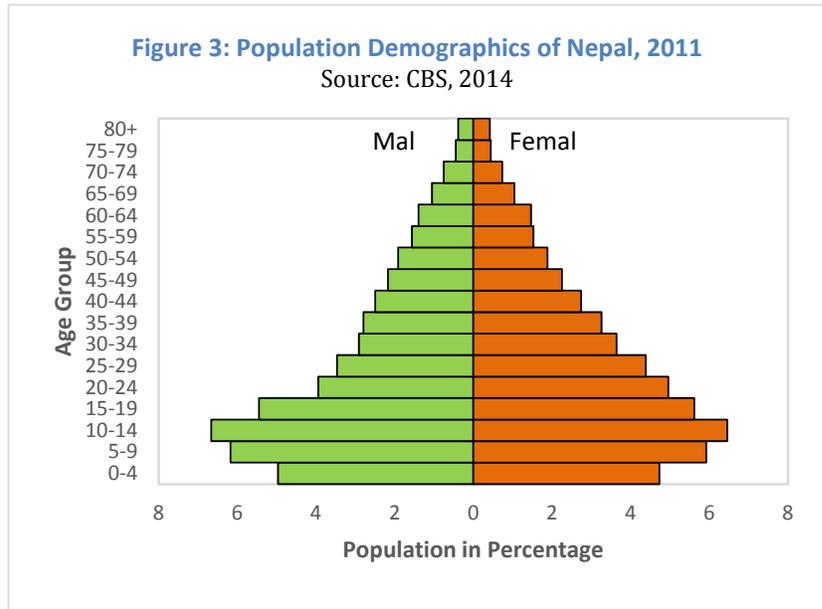
<sup>39</sup> MoYS/GoN (2015): National Youth Policy.

<sup>40</sup> MoYS/GoN (2015): Youth Vision-2025 and 10 Year Strategic Plan.

<sup>41</sup> CBS (2014): Population Monograph of Nepal, Vol. I.

<sup>42</sup> NPC: 13<sup>th</sup> Plan, 2013/14-2015/16.

Lack of employment and economic opportunities resulting from the 10-year armed conflict and prolonged political instability prevail and has been a major reason for an increasing trend of migration in Nepal over the last decade. As reported in the 2010-11 Nepal Living Standards Survey (NLSS), 53% of households in Nepal have at least one absentee living within or outside the country. Especially the absentee population living outside the country has significantly increased: according to census data, there was more than a two-fold increase in the number of Nepalis living away from the country between 2001 and 2011<sup>43</sup>, of which 87.6% were men. 6.3% were between 15 and 34 years of age at departure; 18% between 35 and 54. A large percentage of absentees emigrated to ASEAN member state countries and the Middle East; 41.7% to India.<sup>44</sup> The implications are significant - the average annual growth rate of Nepal's absentee population between 2001 and 2011 was 9.2%. Should this continue, the absentee population would be approximately 4.4m by 2020 and 7m by 2025. With 1,600 individuals leaving for foreign employment every day and remittances estimated to be 29.1% of total GDP, foreign labour migration has become an intrinsic part of life.<sup>45</sup>



The most recent and reliable population data is based on the 2011 Population and Housing Census. Disaggregated census data by age, gender, ethnicity, religion etc. are available at the national through district and community levels. Further analysis of selected demographic, social and economic data from this database is available in Population Monograph Volumes I-III. Other sources of reliable population and related data sources are mainly sample surveys conducted during the last five years, *inter alia* with UNFPA support. However, such surveys often only provide data at national and/or regional levels. Thus, they do not serve district-level planning or monitoring. Nepal also has a Civil Registration and Vital Statistics (CRVS) system that operates at municipality and Village Development Committee (VDC) levels. However, it has only partial coverage in that citizens may or may not register events depending on their individual needs and requirements. Data from this source are therefore considered unreliable.

The GoN has introduced a number of PD-related laws, policies, strategies and programmes, of which the central ones are listed in Annex 8; it has also conducted a number of surveys and assessments related to PD (Annex 8).

### 2.1.5 Gender equality and women's empowerment: achievements, challenges and government policies

Nepal ratified the CEDAW in 1991 and the 2015 constitution affirms equal rights for women; but the status of women is low compared to that of men. Though gender discrimination is

<sup>43</sup> Table 9.3: Population Monograph of Nepal Vol.1, p223: total absentee population in 2001: 762,181; 2011: 1,921,494.

<sup>44</sup> Data on absentee population is regarded as grossly under reported. Total absentee population reported by the 2011 Census is 1,921,494. Source: CBS (2014): Population Monograph of Nepal, Vol. I.

<sup>45</sup> ILO/GIZ (2015): Analysis of Labour Market and Migration Trends in Nepal.

formally prohibited, discriminatory social norms and harmful cultural practices continue in many parts of the country.<sup>46</sup> Disparities persist among different age groups, gender, castes, ethnicities and geographical locations. Issues related to discrimination, impunity, GBV and exclusion prevent the realization of the rights and potential of women. In 2014 Nepal ranked 108<sup>th</sup> of 188 countries on the Gender Inequality Index.<sup>47</sup> Nepal has narrowed the gender gap in the important areas of education, health, employment and political decision-making. Gender parity has been achieved at primary and secondary levels. Even so, the educational attainment of women remains lower than that of men: in the 15-49 age group over 40% of women versus 14% of men have never been to school.<sup>48</sup> In terms of gender parity in the labour force and the political empowerment of women, Nepal was in 112<sup>th</sup> position (out of 142 countries) on the ranking for the Global Gender Gap in 2014 and 61<sup>st</sup> on its political empowerment sub-index. The Global Gender Gap report put Nepal at 88<sup>th</sup> on its health and survival sub-index.<sup>49</sup>

Adolescent girls (aged 10 to 19) are particularly vulnerable. Although the Civil Code defines the legal age of marriage as 20, child marriage is prevalent in Nepal. According to the 2011 Demographic and Health Survey (DHS), two in every five Nepalese women (40.7%) between the age of 20 and 24 were married/in union by 18 years. Among women aged 25 to 49, 55% were married by age 18 and 74% by 20. The median age that girls marry is 17.8 years. However, the proportion of women already married by age 15 declines from 24% among those aged 45 to 49 to 5% among 15-19 year olds indicating a rising age at first marriage. Child marriage occurs more frequently among girls who are the least educated, poorest and living in rural areas.

Despite significant improvements, violence against women and girls continues. Domestic violence predominates, followed by girl trafficking, physical and sexual abuse, social abuses and malpractices such as allegations of witchcraft, chhaupadi (exclusion from the family during menstruation) and dowry. More than one in five women age 15-49 (22%) have experienced physical violence since age 15. 28% of ever-married workers aged 15-49 years have experienced physical or sexual violence committed by their husband/partner. One in five women reported being the victim of physical violence and more than one in ten reported experiencing sexual violence. Only one in four women who experienced any form of physical or sexual violence sought help from any source.<sup>50</sup> Added to this, according to the 2008-09 Nepal Maternal Mortality and Morbidity Study, the leading cause of death among women of reproductive age is suicide. Suicides comprise 16% of all deaths among women and 21% among women aged 15-19. Violence is a significant factor in many suicides.<sup>51</sup>

To address the manifold challenges, a GBV Unit (now called the Gender Empowerment and Coordination Unit) was set up at the Prime Minister's Office and the National Strategy on Gender Empowerment and Ending GBV (2013-17) launched. GBV Elimination and Gender Empowerment District Coordination Committees (GBVEGEDCC) have been set up in all the 75 districts. One-stop Crisis Management Centres (OCMCs) and safe houses have been set up in 21 districts. The GoN has introduced a number of GE-related laws, policies, strategies and programmes, of which the central ones are listed in Annex 8.

## 2.2 The role of external assistance

Nepal has been receiving development assistance for more than six decades and aid continues to play an important role in the socio-economic development of the country.<sup>52</sup> Official Development Assistance (ODA) represented on average about 20% of the national budget over the last five years. The highest amount of ODA was observed in FY 2010-11; it declined thereafter, reached its lowest in FY 2012-13 and started increasing again. In FY 2014-15, total

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<sup>46</sup> <https://www.humanitarianresponse.info/en/operations/nepal/document/nepal-gender-profile>.

<sup>47</sup> <http://hdr.undp.org/en/composite/GII>.

<sup>48</sup> <https://www.humanitarianresponse.info/en/operations/nepal/document/nepal-gender-profile>.

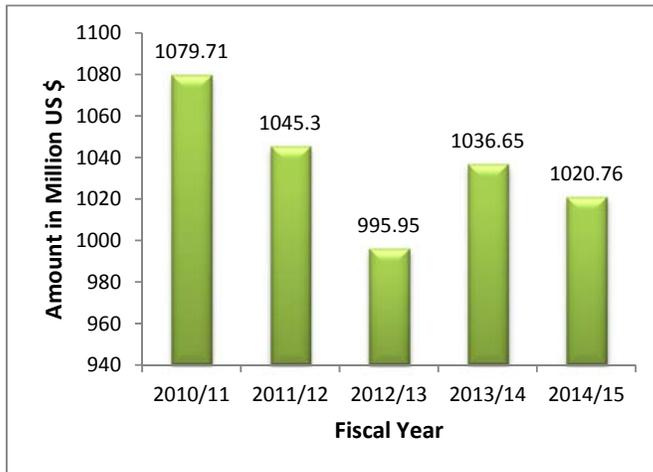
<sup>49</sup> <https://www.weforum.org/reports/global-gender-gap-report-2014/>.

<sup>50</sup> Nepal 2011 Demographic Health Survey, MoHP, 2011.

<sup>51</sup> <http://nhsp.org.np/Document/nepal-maternal-mortality-and-morbidity-study-200809/>.

<sup>52</sup> Unless stated otherwise, this whole section is based on GoN/MoF (2016): Development Cooperation Report FY 2014-15.

**Figure 4: ODA Flow Trends FY 2010/11 – FY 2014/15**  
 Source: GoN/MoF: Development Cooperation Report 2016



ODA flow was slightly over \$1,026m (Figure 4). The overall trend of ODA flows in relation to disbursements (around \$1 billion annually) remained constant over the period of five years. The volume of aid disbursement in FY 2014-15 reached a total of \$1.13 billion, of which ODA contribution was \$1,020.75m (90%) and INGO contribution \$116.89m (10%). Despite the devastating earthquake in April 2015, ODA disbursement stood at almost the similar level as compared to the previous FY.

Of total ODA contributions, about 45% was provided by multilateral and 55% by bilateral

donors. The top five multilateral development partners in FY 2014-15 were the World Bank Group, the Asian Development Bank, the UNCT, the European Union, and the Global Fund to Fight AIDS, Tuberculosis and Malaria. They contributed approximately 43% of ODA. The top five bilateral donors were the United Kingdom, USAID, Japan, China and Switzerland. They contributed approximately 40%. In FY 2014-15, the health sector disbursed the largest amount of ODA (17.4%) followed by local development, education, road transportation and energy. These top five sectors received approximately 60% of total ODA. The World Bank Group has been the lead donor in education, economic reform and agriculture; the Asian Development Bank for road, energy, urban development and drinking water. The UNCT has been the lead partner for remaining social sector areas such as SRH, GE and social inclusion, GBV and human rights. Similarly, USAID has led in the health sector, the European Union in local development and the United Kingdom in home affairs. According to the MoF, NPR 410 billion were pledged for responding to the 2015 earthquake. As of March 2016, almost 30% had been realized with the remaining NPR 290 billion expected over the following three years for achieving recovery and reconstruction goals.<sup>53</sup> The UNCT delivered approximately \$188.2m, of which \$130.7m was for development assistance and \$57.5m was for humanitarian assistance in 2015.<sup>54</sup>

### Chapter 3: UNFPA Programmatic Response

*This chapter provides information for the reader to understand the current UNFPA CP, the subject of the present evaluation. The following sections focus on UNFPA's programmatic response (Section 4.1) and financial resources (Section 4.2).*

UNFPA support to Nepal began in 1971. During the 6<sup>th</sup> UNFPA country programme (2008-12) UNFPA expanded its coverage from six to 18 districts that were making slow progress in achieving the goals of the ICPD in three geographic clusters.<sup>55</sup> UNFPA's local representation is through RSOs in Dang for the Mid-western to Western regions, Dhangadi for the Far-western region and Janakpur for the Central to Eastern regions.

<sup>53</sup> GoN (2016): Post Disaster Recovery Framework (PDRF) 2016-2020.

<sup>54</sup> UN Resident Coordinator's Annual Report 2015; [http://un.org.np/sites/default/files/20160215\\_annualreport\\_2015.pdf](http://un.org.np/sites/default/files/20160215_annualreport_2015.pdf).

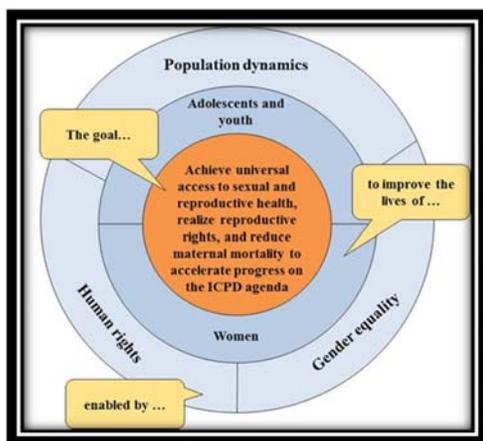
<sup>55</sup> Source: CPAP 2013-17.

UNFPA is implementing its 7<sup>th</sup> CP. The CPD 2013-17 was approved by the UNFPA Executive Board in September 2012 and operationalized through the CPAP 2013-17, signed in February

2013. At the highest level, CP7 intends to contribute to UNFPA’s corporate goal depicted in Figure 5 – i.e., to achieve universal access to SRH, to promote reproductive rights, to reduce maternal mortality, and to accelerate progress on the International Conference on Population and Development (ICPD) agenda and MDGs 5A and 5B, in order to empower and improve the lives of underserved populations, especially women and young people (including adolescents), enabled by an understanding of population dynamics, human rights and gender equality, and driven by country needs and tailored to the country context.

**Figure 5 UNFPA’s “Bull’s Eye”**

Source: UNFPA SP 2014-17



CP7 was developed drawing on lessons learned and a series of national and district level consultations. In particular, an evaluation of CP6 noted progress towards national ownership, strategic alignment of the

programme to enhance sustainability, accountability and national system strengthening and a number of achievements in programme results. It found that the programme had helped to: (a) position UNFPA within the health-sector programme; (b) enhance the national response to GBV by working with UN organizations and other donors; and (c) implement the population and housing census.<sup>56</sup> Lessons learned pointed to the need to:

- sharpen the focus on evidence-based FP advocacy efforts and policies, including research on the reasons for the stagnant contraceptive prevalence rate;
- increase access to youth-friendly sexual and reproductive health services, including by addressing social barriers to access;
- pay greater attention to involving men in violence-prevention efforts;
- address the gender dimension of health systems and services;
- conduct research on migration, urbanization and ageing; and
- provide continued support to data management systems.

The April 2015 earthquake led to a temporary shift in priorities and resources to 14 severely-affected districts (with only one UNFPA district under the regular programme being amongst districts the 14 most affected districts). UNFPA responded under the umbrella of the Nepal Flash Appeal as part of the health and protection clusters.

UNFPA’s Business Model<sup>57</sup>, introduced in 2014, determined four modes of engagement for country-level interventions depending on a country’s particular needs and ability to finance – i.e., advocacy and policy dialogue, capacity development, knowledge management and service delivery (Table 6). Nepal was classified as “red” where UNFPA is expected to make full use of all modes of engagement to achieve its objectives.

**Table 6: Modes of UNFPA Engagement by Country Classification**

<i>Ability to finance</i>	<i>Need</i>			
	<b>Highest</b>	<b>High</b>	<b>Medium</b>	<b>Low</b>
<b>Low</b>	A/P, KM, CD, SD	A/P, KM, CD, SD	A/P, KM, CD	A/P, KM
<b>Lower-middle</b>	A/P, KM, CD, SD	A/P, KM, CD	A/P, KM	A/P
<b>Upper-middle</b>	A/P, KM, CD	A/P, KM	A/P	A/P
<b>High</b>	A/P	A/P	A/P	A/P

<sup>56</sup> CPD.

<sup>57</sup> UNFPA SP 2014-17 Annex 3.

A/P = Advocacy and policy dialogue/advice      CD = Capacity development  
 KM = Knowledge management                      SD = Service delivery

Source: UNFPA SP 2014-17

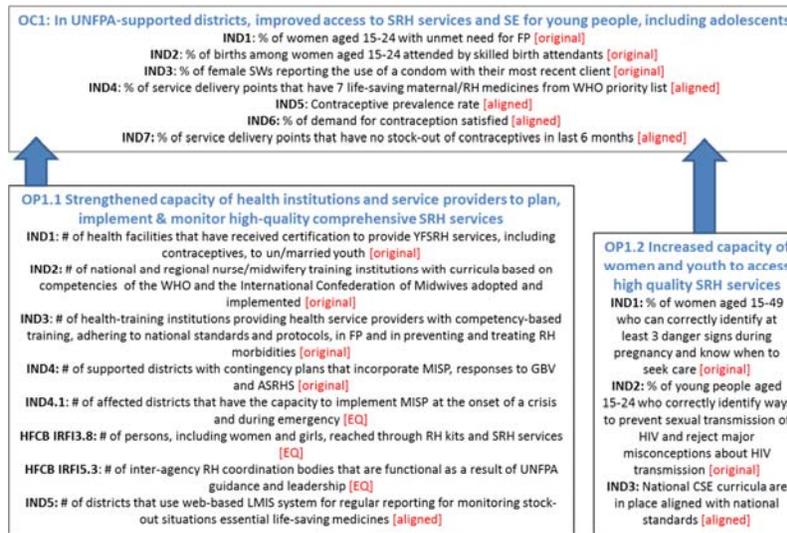
### 3.1 The UNFPA Nepal country programme 2013-17

#### 3.1.1 Sexual and reproductive health and rights

Outcome 1 of CP7 “Improved access to sexual and reproductive health services and sexuality education for young people, including adolescents” contributes primarily to UNDAF Outcome 1: “Vulnerable and disadvantaged groups obtain improved access to basic essential social services and programmes in an equitable manner”. Outcome 1 ultimately contributes to achieving the national development goal “increased access to and utilization of high-quality essential health care services” as put forward in the NHSP II and its Implementation Plan.

Under the SRH programmatic area, UNFPA supports national efforts to improve the SRH of women of reproductive age with a special focus on adolescents and youth as well as marginalized women. To achieve this goal, the programme focuses on both the supply and demand sides of SRH.

**Figure 6: Nepal CP7 SRH Outcome, Outputs & Indicators**



Source: Evaluation Team based on Re-aligned RRF

Outcome 1 is expected to be achieved through strengthening the capacity of health institutions and service providers to plan, implement and monitor high-quality comprehensive SRH services (OP1.1) and increasing the capacity of women and youth to access high quality SRH services (OP1.2). Interventions under OP1.1 include capacity building/training, FP and commodity security, maternal health, ASRH services, emergency preparedness and response; while OP1.2 comprises SRH information/education, particularly CSE and HIV education. Project activities under OP1.1 are by far more numerous and weighty.

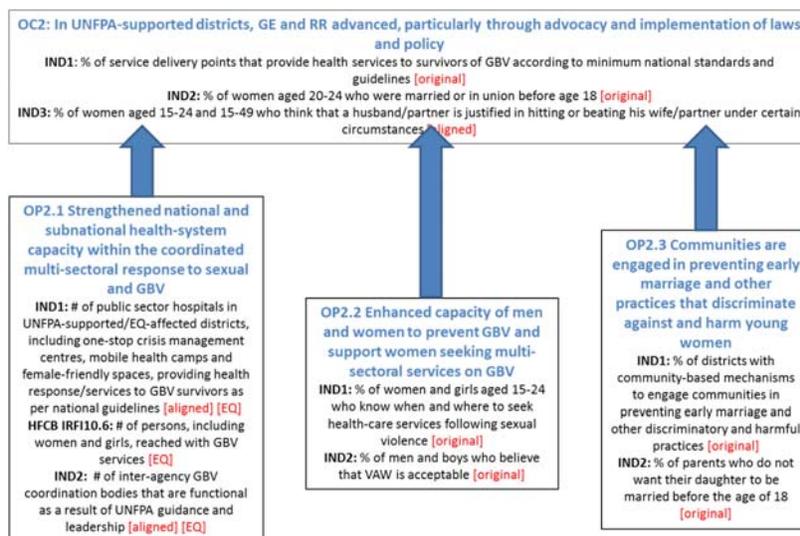
In addition to national-level partnerships with government departments, UNFPA has entered into agreements with the DDCs of the UNFPA-supported districts with the aim to implement project interventions designed and agreed upon by national level bodies through their respective district units. SRH interventions have been funded through UNFPA Regular Resources (RR), various UNFPA Thematic Funds (including UNFPA Supplies and Maternal Health Thematic Fund), the UNFPA Emergency Response Fund (ERF) as well as GIZ, the

Government of Australia, Japan, GAVI, UBRAF, the UN Central Emergency Response Fund (CERF) and UNFIP.<sup>58</sup> The CPE design report provides more details.

### 3.1.2 Gender equality and reproductive rights

This programmatic area (CP Outcome 2) focuses on building national capacity in the health sector to prevent and address GBV as part of multi-sectoral efforts and on enhancing the knowledge and capacity of men, women and communities to prevent GBV, child marriage and other harmful practises (Figure 7).

Figure 7: Nepal CP7 GE Outcome, Outputs & Indicators



Source: Evaluation Team based on Re-aligned RRF

Under CP7, GE interventions were designed to contribute to UNDAF Outcome 3 that seeks to ensure that vulnerable and stigmatized groups experience greater self-confidence, respect and dignity. CP Outcome 2 intends for GE and RR to be advanced particularly through advocacy and implementation of policies. The three outputs stipulated to achieve OC2 are:

- OP2.1: Strengthened national and subnational health system capacity within the coordinated multi-sectoral response to sexual and gender-based violence
- OP2.2: Enhanced capacity of men and women to prevent gender-based violence and support women seeking multi-sectoral services on gender-based violence
- OP2.3: Communities are engaged in preventing child marriage and other practices that discriminate against women and harm young women

Besides using UNFPA RR and UNFPA ERF, Outcome 2-related activities were funded through a range of external sources – i.e., Swiss Agency for Development and Cooperation (SDC), Government of Japan, Government of Australia, GIZ, DFID, the UN Peace Fund, the UN Central Response Fund, OCHA, Global Giving Grant and, as of August 2016, Norway. The CPE design report provides more details.

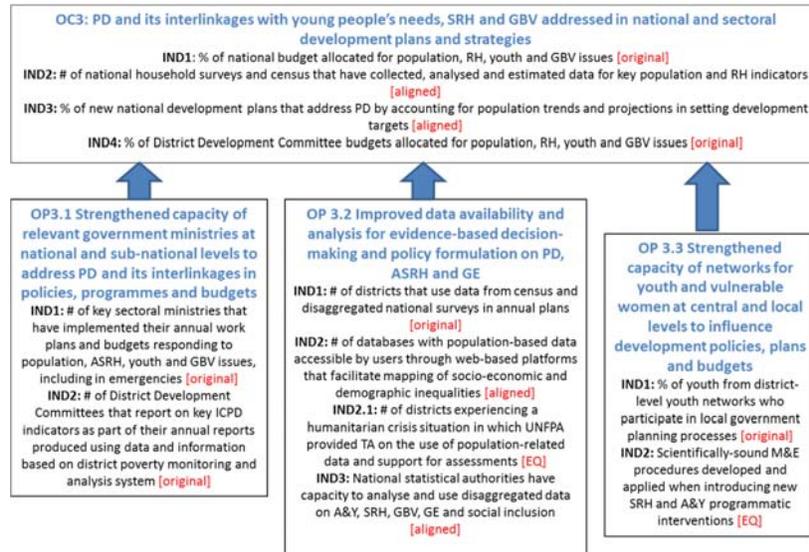
### 3.1.3 Population dynamics

CP Outcome 3 contributes to UNDAF Outcome 5 “Institutions, systems and processes of democratic governance are made more accountable, effective, efficient and inclusive”. It includes three outputs. It focuses on ensuring that national, sectoral and decentralized policies and plans are responsive to population dynamics and their inter-linkages with GE, poverty reduction, and the RH needs of young people including FP. Moreover, it includes support for building national capacities in data generation, processing, analysis, dissemination and use for

<sup>58</sup> Resources for CSE are also expected from KOICA through UNESCO as soon as agreement is signed.

inclusive development planning and programme monitoring; and on enhancing civil participation in policy formulation, planning and monitoring (Figure 8).

**Figure 8: Nepal CP7 PD Outcome, Outputs & Indicators**



Source: Evaluation Team based on Re-aligned RRF

In the context of low government capacity for planning and programming activities on population issues, OP3.1 is concerned with capacity building of line agencies at national and district levels to incorporate population, SRH, youth and GBV issues in their annual plans and utilize data and information in activity planning and reporting. Since considerable PD-related disaggregated and updated data sets are not available, OP3.2 interventions are aimed at improving data availability and analysis, developing databases as well as capacity building of national authorities to analyse and use disaggregated data. In the context of low participation of A&Y and vulnerable women in policy making and planning processes, OP3.3 aims at strengthening the capacity of A&Y and vulnerable women networks at central and local levels to influence development policies, plans and budgets.

The PD programmatic area is mostly funded through UNFPA RR. It has been implemented through the Population Division of the Ministry of Health and Population MoHP<sup>59</sup>, the Central Department of Population Studies of the Tribhuvan University (CDPS/TU), the Ministry of Youth and Sports (MoYS), the Local Governance and Community Development Programme 2013-17 (LGCDP<sup>60</sup>) of the Ministry of Federal Affairs and Local Development (MOFALD), the Central Bureau of Statistics (CBS), the youth-led organization Restless Development and DDCs. The CPE design report provides more details.

### 3.1.4 Emergency preparedness and response

Emergency preparedness and response is mainstreamed throughout CP7. A reading of the CPD and CPAP reveals an overarching intention for UNFPA to integrate risk reduction in programming. The CPAP concretized *emergency preparedness* – i.e., by way of

- technical support for incorporating MISP components, including SRH, GBV and A&Y, in district contingency plans
- advocacy for incorporating MISP into existing pre- and in-service health training curricula

<sup>59</sup> Since 2015, the Population & Environment Management Division of the Ministry of Population & Environment (MoPE).

<sup>60</sup> LGCDP 2016 Annual Report: The purpose of LGCDP is to improve local governance for effective service delivery and citizen empowerment. The programme has adopted a framework to strengthen decentralization, devolution and accountable local governance system which makes basic service delivery effective and efficient and empowers citizens mainly women, children and disadvantaged groups.

- building capacities of service providers at national, regional and district levels on humanitarian preparedness and response
- making available RH kits for the event of an emergency

In the aftermath of the April 2015 earthquake, the CPAP RRF was modified to include UNFPA's *emergency response* consisting of support for

- MISP implementation;
- emergency GBV prevention and response services, including the creation of Female Friendly Spaces;
- coordination around RH and GBV;
- evidence-based assessments for humanitarian assistance; and
- monitoring and evaluation of humanitarian response

Essentially, emergency preparedness and humanitarian assistance has fallen under the following CP outputs: OP1.1, OP2.1, OP3.1, OP3.2 and OP3.3.

Funds for responding to the April 2015 earthquake were redirected from UNFPA's budgeted RR; they were received from the Government of Australia (allocated to SRH and GE), the United Kingdom (GE), the Government of Japan (SRH and GE), GIZ (SRH and GE), the Government of Switzerland (GE), the UNFPA ERF (SRH, GE and PD) and the UN CERF (SRH and GE). UNFPA also received additional RH kits from the UNFPA Supplies Programme (in kind for an approximate amount of \$500,000), additional support through the Regional Programme (from Australia) to purchase additional dignity kits, as well as small and in-kind contributions from different sources. Humanitarian assistance Implementing Partners were Jhpiego (GE), the Midwifery Society of Nepal (SRH), the Centre for Victims of Torture (GE), the Epidemiology and Disease Control Division (EDCD) (SRH), CARE Nepal (SRH and GE), ADRA (SRH), FPAN (SRH and GE) and the Nepal Red Cross Society (SRH, GE). UNFPA also supported a socio-demographic impact study in the 14 earthquake-affected districts implemented through CDPS/TU (PD) and a youth-led initiative through Restless Development and three youth organizations (Yuwa, Y-Peer and Yuwalaya). PD activities were funded through the UNFPA ERF.

### 3.2 The country programme financial structure

The initial proposed indicative commitment of UNFPA as per the CPD (Table 7) is \$30.5m: \$23m from RR and \$7.5m through co-financing modalities and/or other including RR. This amount was to be divided among three core programme areas: SRH \$12.2 (\$9.2m from RR); followed by PD \$8.9m (\$6.9m from RR); and GE \$8.2m (\$5.7m from RR); as well as programme coordination and assistance \$1.2m from RR.

**Table 7: Indicative Commitments by Programmatic Area 2013-17 (in millions of US\$)**

Programmatic Area	Regular Resources	Other Resources	Total	%
Young people's SRH and SE	9.2	3.0	12.2	40.0%
GE and RR	5.7	2.5	8.2	26.9%
Population dynamics	6.9	2.0	8.9	29.2%
Programme Coordination and Assistance (PCA)	1.2	-	1.2	3.9%
<b>Total</b>	<b>23.0</b>	<b>7.5</b>	<b>30.5</b>	<b>100%</b>

Source: CPD 2013-17

At the request of the evaluation team, the UNFPA CO undertook an analysis of the country programme finances.<sup>61</sup> Table 1 in Annex 4 shows the annual Regular Resource spending ceilings and available Other Resources (OR) and Table 2 utilization figures. 2015 was a peak in terms of income (\$8.75m) and expenditure (\$8.63m). As of November 2016, UNFPA had utilized 92.2% of total funds: 95.2% of RR and 86.1% of OR. Similarly, Table 3 indicates annual expenditures per programmatic area. SRH is the largest programme component in monetary terms. Contrary

<sup>61</sup> Financial tables are included in Annex 4. The amounts for 2016 are provisional and as of November 2016 only.

to indicative commitments, it is followed by GE and then PD. In all instances, actual OR budgets are already larger than originally planned for the whole CP cycle.

Table 4 provides information about the origin of OR by programmatic area. Donors are numerous and include bilateral donors (first and foremost Switzerland, DFID and Japan), UNFPA Trust Funds, the UNFPA ERF, UN Trust Funds, other multilateral organizations and small contributions – mainly for SRH and GE-related interventions.

Tables 5-6 provide data on the extent to which CP7 was implemented using the DEX and NEX modalities – by year and programmatic area. NEX was highest in absolute terms (\$3.41m) in 2015, the year of the devastating earthquake. NEX amounts to 45.6% of all expenditures between 2013 and November 2016. The GE programmatic component has made least use of NEX as compared to DEX. Table 7 shows NEX utilization by Implementing Partner. The number of UNFPA Implementing Partners is high (46) and includes governmental (central and district-level) and non-governmental entities. The largest amount received by an individual Implementing Agency for the four years under evaluation is \$1.05m (ADRA), followed by Jhpiego (\$0.86m) and FPAN (\$0.42m).

During the period under review, the CO received a significant amount of contraception assistance worth \$ 5.48m directly from the UNFPA Commodity Security Branch (CSB) for further distribution to the GoN and NGOs (Table 8).<sup>62</sup> CSB funding contributes to the national FP programme to meet the shortfall in commodity requirements due to delays in the national procurement system.

## Chapter 4: Findings

*This part of the evaluation report provides an assessment of the performance of the UNFPA 3rd CP 2013-17 three-and-a-half years into its implementation against indicators of achievement developed by the evaluation team considering the CPAP RRF and consulted with the UNFPA CO. It is structured along the evaluation criteria and corresponding evaluation questions.*

### 4.1 Relevance of the UNFPA 7<sup>th</sup> Country Programme

**EQ1 Alignment: To what extent was CP7 design, planning and implementation: (1) aligned with government priorities; (2) consistent with the needs of the population, in particular young people and marginalized/vulnerable groups; and (3) aligned to relevant UN system and UNFPA policies and strategies?**

#### A.1.1 Alignment and responsiveness of CP7 to government priorities at national and district levels

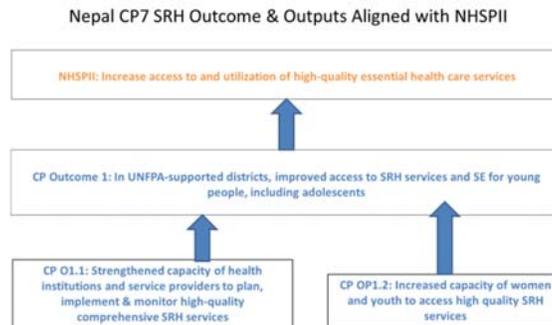
**IND1.1.1&IND1.1.2 CP7 is well aligned with relevant national legislation, policies, strategies and programmes. Its design under the National Health Sector Programme II and annual planning were a joint effort. UNFPA was responsive at the strategic level. It adapted CP7 in response to the violent earthquake in April 2015.** Consistency with GoN priorities was ensured through the CPAP 2013-17, co-signed by UNFPA and the MoF. Over time, alignment of CP7 planning was sought through contracts and Annual Work Plans (AWPs) with selected central-government Implementing Partners, particularly in SRH and PD. Furthermore, evidence of safeguarding alignment at national level is found in joint monitoring missions and annual review meetings.

The RRF explicitly links outputs and outcomes to the National Health Sector Programme 2010-15 (NHSP II) (Figures 9-11). Moreover, CP7 is considered consistent with a number of key national and sectoral policies and programmes. They are referred to throughout this report.

<sup>62</sup> Not part of the spending ceiling or expenditures of UNFPA Nepal but provided in kind to the GoN and NGOs.

According to two key informants, alignment was facilitated by the existence of a comprehensive legal and policy framework, for which UNFPA frequently conducted advocacy and provided policy advice.

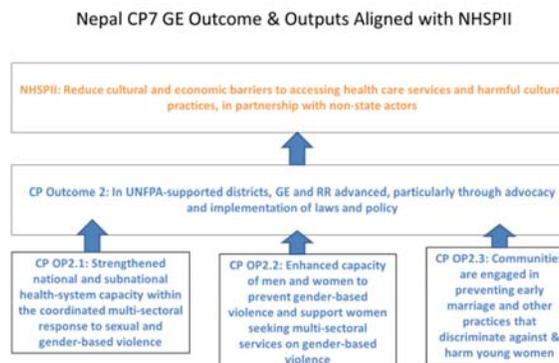
**Figure 9: Nepal CP7 SRH Outcome & Outputs Aligned with NHSP II**



Source: Evaluation Team

The SRH programme should contribute to the national goal to increase access to and utilization of high-quality essential health care services. UNFPA has got its priorities right. Interviewees emphasized UNFPA support for GoN priorities where data and analyses as well as domestic skills and funding are insufficient to satisfy needs – i.e., reproductive health commodity security; FP and in particular Long-Acting Reversible Contraception (LARC) and district-level FP micro-planning; RH morbidities; and ASRH. They appreciated UNFPA’s support for initiating midwifery education as well as for obstetric fistula (OF).

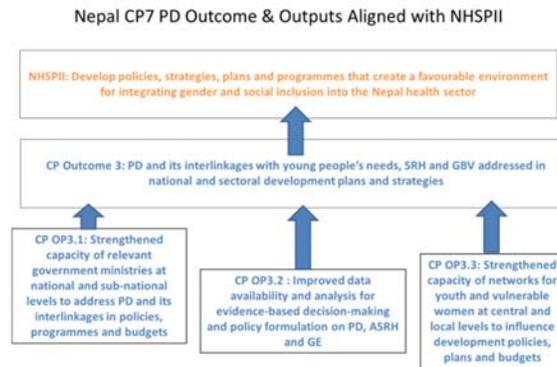
**Figure 10: Nepal CP7 GE Outcome & Outputs Aligned with NHSP II**



Source: Evaluation Team

The GBV programme should contribute to the national goal to reduce cultural and economic barriers to accessing health care services and harmful cultural practices. Stakeholders especially emphasized UNFPA’s support for OCMCs and safe houses, psycho-social counselling, inter-generational dialogue, and the Social and Financial Skills Package (SFSP). Furthermore, UNFPA’s work in the area of child marriage was specified as essential. Its support for integrating priests and astrologers in preventing GBV, child marriage and other harmful practises was commended as tactical and an innovative approach.

**Figure 11: Nepal CP7 PD Outcome & Outputs Aligned with NHSP II**



Source: Evaluation Team

The PD programme should contribute to the national goal to create a favourable environment for integrating gender and social inclusion in the health sector through policies, strategies, plans and programmes. GoN stakeholders emphasized the relevance of policy-level and programme support provided by UNFPA on youth development. Interviewees were particularly clear that support for youth empowerment was also very much in line with government priorities as embodied, for instance, in the 13<sup>th</sup> Plan and the 14<sup>th</sup> Plan Approach Paper, the Youth Vision 2025, the National Youth Policy and the LGCDP.

As will be elaborated (IND9.2.1), UNFPA has played a leading role in the cluster system in support of the GoN National Disaster Response Framework (NDRF). Following the earthquake in April 2015, the UNFPA RRF was adapted and resources mobilized/shifted in support of the GoN's response efforts in the 14 most-affected districts, only one of which was a UNFPA priority district. Despite some delays encountered in its regular programming because of the urgent attention given to earthquake survivors, no interviewee thought to question this decision.

**IND1.1.1&1.1.2 CP7 is clearly an integral part of implementing district development plans. The greatest need for flexibility was in response to the April 2015 earthquake in Sindhuli where the Annual Work Plan was successfully re-orientated to meet urgent SRH and GBV needs.** As this evaluation revealed, the percentage of district-level budget allocations for population, SRH, youth and GBV/women's empowerment has increased considerably across UNFPA's priority districts. UNFPA not only influenced periodic and annual district development planning (IND5.2.6), it also clearly engaged in their implementation. It did so by providing technical expertise as well as earmarked funding through DDCs as UNFPA Implementing Partners. As part of implementation, UNFPA also participated in joint monitoring. In all four visited districts, local government representatives confirmed that UNFPA support was aligned through the regular government planning process. Support was described as "appropriate", "aligned", "crucial", "in line", "highly relevant", "synchronized", "responsive", and "close". UNFPA representatives in the regions and districts perceive themselves to be bridging important capacity and financial gaps consistent with UNFPA's mandate and CP7. As will be explained below (IND7.3.1), stakeholders considered the physical presence of UNFPA staff pertinent in terms of optimizing consistency, integration and government ownership.

The greatest need for responsiveness and flexibility that the evaluation team noted was in Sindhuli district because of the devastating earthquake in April 2015. Within reasonable time, UNFPA and the DDC revised their 2014-15 AWP to re-programme remaining funds for SRH and GBV to help implement the MISP, including establishing mobile RH camps and providing dignity kits and sanitary pads to the eleven most-affected VDCs. Later on, additional in-kind support was given and extra emergency funding channelled to the district through the 2015-16 AWP.

#### A.1.2 Alignment of CP7 with the needs of young people and vulnerable/marginalized women

**IND1.2.1&IND1.2.2 Young people are not only target beneficiaries; they are also partners in action. Adolescents and youth participated in CP7 design; they have been less**

**systematically represented in annual planning. UNFPA has made a conscious effort to consult and involve young people in CP7 implementation. Deliberate involvement of vulnerable and marginalized women in CP7 design and planning, to ensure alignment with their particular needs, has been less.** UNFPA staff confirmed that young people participated in national and district-level consultations leading up to CP7, and that the intention is to ensure their renewed involvement in CP8 design. Annual planning builds on Annual Review Meetings in Kathmandu; in the districts, it builds on multi-stakeholder consultations. Young people were not represented at Annual Review Meetings apart from the youth-led organization Restless Development, an Implementing Partner. In the districts, there seem to have been different approaches to A&Y participation in UNFPA annual planning.

In terms of CP7 *implementation*, the most obvious strategic collaboration with A&Y is in the PD programmatic area where UNFPA has worked with youth-led organizations and stakeholders at the central level to influence youth policies, action plans and programmes, and where it has facilitated the formation, strengthening and institutionalization of youth networks in its priority districts to influence local-level policy and planning processes. Equally important is collaboration with girls' circles within the GE programme to empower adolescent girls to leverage UNFPA's efforts to inform and educate communities about SRH, GBV and child marriage. Moreover, A&Y were consulted for the "Barrier Study" and the "CSE Review". They were part of a bottom-up process to develop the UNFPA/NHEICC BCC Strategy and Implementation Plan. A&Y were also involved in developing the ASRH training package for health service providers; and AFHS centre clients are heard as part of final decisions to certify AFHS centres. In the aftermath of the 2015 earthquake, UNFPA trained A&Y volunteers as peer educators and enumerators in the context of the Post-Disaster Needs Assessment (PDNA), funded by the World Bank and UNDP.

While UNFPA has clearly targeted vulnerable and marginalized women such as FSWs and GBV survivors as beneficiaries (IND1.3.3), the evaluation team did not come across evidence that UNFPA had purposefully invited representatives to participate in CP7 design and planning. Reasons stated for this were lack of time and capacities, and the need to first identify and build working relationships with local stakeholder groups/organizations.

**IND1.2.3 CP7 has been well informed by data, analyses and knowledge products; some assessments of CP7 performance were conducted.** *UNFPA has created and utilized multiple datasets and analyses to inform CP7 planning and implementation.* In 2012, it commissioned a baseline study to inform Outcome 3 (PD) planning. Follow-up data collection studies were undertaken yearly. In 2013, UNFPA conducted a perception survey to gather baseline data for GE and SRH-related perception-based indicators.<sup>63</sup> An externally-commissioned strategy validated the CPAP focus to engage men and boys, parents and communities, including religious leaders, to address the issue of child marriage and harmful practises.<sup>64</sup> Obviously, UNFPA also supported and used CBS, DHS, Multiple Indicator Cluster Survey (MICS) and Health Management Information System (HMIS) data and related analyses to inform its work. In each of the districts visited by the evaluation team, assessments had been conducted to identify low CPR VDCs and inform FP micro-planning. After the April 2015 earthquake, the CO participated in and used the findings of the Post-Disaster Needs Assessment (PDNA).

*Together with partners, UNFPA also produced a number of knowledge products.* In SRH, for instance, it conducted studies on selected RH morbidities and on health-related quality of life of women suffering from pelvic organ prolapse before and after surgery. The CO, fulfilling a GPRHCS requirement and harmonized with the National Health Facility Survey, also

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<sup>63</sup> An end-line perception survey is planned for 2017.

<sup>64</sup> International Centre for Research on Women (ICRW): "Engaging Men and Boys, Communities and Parents to End Violence against Women, Child Marriage and Other Harmful Practices in Nepal", January 2014; <http://nepal.unfpa.org/publications/engaging-men-and-boys-communities-and-parents-end-violence-against-women-child-marriage> (English).

commissioned the annual “Facility-based Assessment for Reproductive Health Commodities and Services”. ASRH work was very much directed by the findings and recommendations of the “Barrier Study” and the “CSE Review”. In GBV, UNFPA supported an assessment by the Nepal Health Sector Programme of the OCMCs and organized meetings to share the findings.<sup>65</sup> Furthermore, a study and policy brief were prepared on “Tracking Cases of Gender-based Violence in Nepal: Individual, Institutional, Legal and Policy Analysis”<sup>66</sup>, and the CO participated in a regional study on “Sex Work, Violence and HIV in Asia – from Evidence to Safety”. In the area of data availability and analysis, UNFPA mobilized support for publishing the Population Monographs of Nepal; it supported further analysis of the 2011 DHS. As part of its support for youth empowerment, UNFPA provided financial and technical support to the MoYS for researching and publishing the report “Nepali Youth in Figures”<sup>67</sup>; it supported Restless Development to produce a “Media Monitoring Report on Youth Engagement in Post-Earthquake Relief Campaign”. After the earthquake, UNFPA, in collaboration with International Office of Migration, supported a study entitled “Socio-demographic Impact of the Earthquake 2015”. *Some assessments of UNFPA’s performance were conducted, mainly early on in the CP7 cycle. In 2013, UNFPA conducted an assessment of its flagship adolescent girls’ programme Choose Your Future. Findings and recommendations fed into the content and design of the SFSP.*<sup>68</sup> In collaboration with UN Women and UNICEF, UNFPA commissioned a final evaluation of the Trust Fund project “Multi-Sectoral Gender-based Violence Response at the District Level in Nepal”. In 2014 DFID assessed UNFPA’s interventions as part of its GPRHCS Annual Review. Most recently, in May 2016, UNFPA supported an evaluation of the MISP for Reproductive Health Services in Post-earthquake Nepal by the Women Refugee Council.

#### A.1.3 Alignment of CP7 with the UNFPA Strategic Plan and UNDAF

**IND1.3.1 CP7 was logically connected to the Mid-term Review of the UNFPA Strategic Plan 2008-13 and aligns well with the Strategic Plan 2014-17 outcome areas.** CP7 was originally designed under the Mid-term Review (MTR) of the UNFPA SP 2008-13 and modified development results framework. In its regular programming, UNFPA has pursued eight outputs across three programmatic areas. The three CPAP outcome statements (one for each programmatic area) were identical to select SP MTR 2008-13 outcome areas – i.e.,

- SP MTR Outcome 1: PD and its interlinkages with young people’s needs, SRH and GBV addressed in national and sectoral development plans and strategies
- SP MTR Outcome 5: Gender equality and RR advanced, particularly through advocacy and implementation of laws and policy
- SP MTR Outcome 6: Improved access to SRH services and sexuality education for young people, including adolescents

The RRF was later re-aligned to the UNFPA SP 2014-17 IRF. This re-alignment brought no changes to the number or formulation of CP outcomes or outputs; it did at the level of outcome and output indicators. Existing results statements were programmatically re-connected to the four new SP outcomes as depicted in Figure 12. No separate A&Y programme component was created.<sup>69</sup> Outcome 1 was aligned to both SP 2014-17 Outcomes 1 (SRH) and 2 (A&Y).

**Figure 12: Linkages between CP7 and UNFPA’s SP 2014-17**

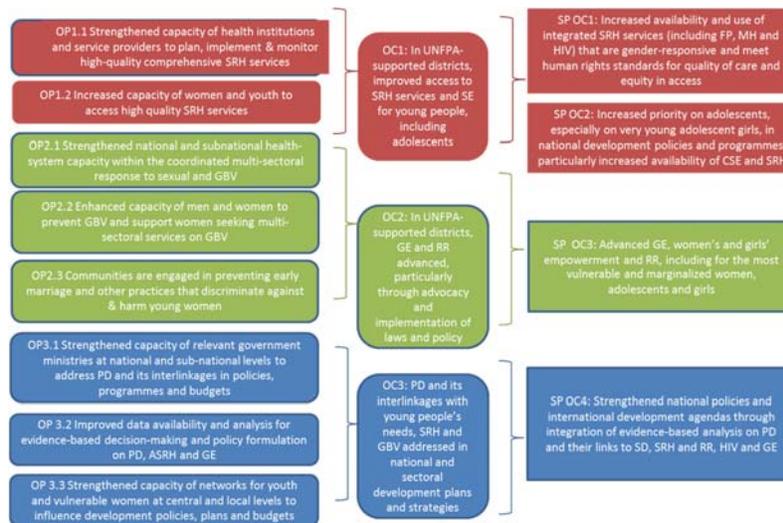
<sup>65</sup> MoH: Assessment of the Performance of Hospital-Based One Stop Crisis Management Centres, 2013.

<sup>66</sup> 2013. UNFPA, DFID and UN Women.

<sup>67</sup> December 2014.

<sup>68</sup> Later, the MoWCSW allocated regular funds to scale-up the programme, renamed Kishori Bikash Karyakram, in all 75 districts. Source: Evaluation of UNFPA Support to Adolescents and Youth 2008-2015.

<sup>69</sup> This was not a corporate requirement.



Source: Evaluation Team based on Re-aligned RRF

**IND1.3.2 Programmatic synergies and collaboration between the CP7 programme components are evident, both in UNFPA's regular programme and earthquake response, but could be further explored.** UNFPA's "bull's eye" requires that each CO pools its forces and resources and works in a synergistic fashion rather than operating in silos. This CPE revealed general satisfaction and some good examples of office-wide collaboration. At the same time, two key informants felt that there was room for more collaborative efforts and that information flow was important to identify additional opportunities. Support for GBV survivors is one such good example. As part of its regular programming, UNFPA has worked with the health sector to strengthen OCMCs in district hospitals; as part of the referral system, it has supported safe houses, for which WCOs are responsible. This has proven a good entry point for collaboration between health sector and protection actors. Another example of working across outcome areas are UNFPA's public outreach and BCC activities to address issues related to the inter-connected areas of SRH, including pregnancy danger signs and HIV prevention, as well as GBV prevention and child marriage. Similarly, both the SRH and the GE programme components are making use of the SFSP, locally known as "Rupantaran". Rupantaran<sup>70</sup>, co-designed by UNICEF and UNFPA, aims to provide comprehensive social and financial skills to A&Y aged 10-19. It includes modules on self-awareness, gender and social inclusion, civic engagement, GBV and SRH.

The UNFPA CO has also engaged at the policy level through advocacy and policy dialogue/advice. Work to improve data availability and analyses on PD, SRH, youth and GBV in order to influence the national policy framework and its implementation has been a common undertaking, with in-house technical support for data gathering and research from the PD component. For the benefit of the entire country programme, the PD component is the main counterpart for the National Forum for Parliamentarians on Population and Development (NFPPD) and co-leads the UNCT SDG Working Group.

Programmatic collaboration and synergy between the three CP7 programme components was also well demonstrated during the 2015 earthquake response. Mobilization of youth as voluntary peer educators and enumerators and provision of mobile RH camps and female-friendly spaces (FFSs) that provided contraceptives and dignity kits are good examples.

**IND1.3.3 UNFPA has clearly targeted women and girls of reproductive age who are vulnerable and marginalized, most prominently GBV survivors and women at risk of being married early. It has not specifically targeted the particular needs of very young adolescents (10-14) who are a corporate strategic priority for 2014-17.** The overall goal of CP7 is to support national efforts to improve the SRH of the most marginalized adolescent girls

<sup>70</sup> "Transformation" in English.

and women. While not explicit, further analysis of the CPD and CPAP suggests marginalized and vulnerable girls between 15 and 24 and women up to 49 years of age. The age group 15 to 24 correlates exactly with the UN's definition of youth and largely with Nepal's definition of youth as per the Youth Vision 2025 – i.e., 16 to 24.

While in line with the target populations of the UNFPA SP 2014-17<sup>71</sup>, the evaluation team noted that CP7 was not re-aligned to reflect the increased corporate focus on very young adolescent girls aged 10-14.<sup>72</sup> While interventions at policy and programme level - such as regards the 2013 National Plan of Action on the Holistic Development of Adolescents<sup>73</sup> and AFHS - have also benefited very young adolescents, the only support with a targeted component benefiting this age group (although not yet implemented) is through CSE in primary school. Interviewees voicing an opinion noted that there was very little guidance forthcoming from UNFPA headquarters (HQ); that there was a paucity of data; that engaging with very young adolescents was difficult; and that they were too young for SRH services.

CP7 has largely been implemented in 18 districts that were making slow progress towards the goals of the ICPD.<sup>74</sup> This in itself speaks for an appropriate targeting of vulnerable groups. Within districts, the evaluation team was frequently told that target communities were selected based on vulnerabilities such as low CPR pockets - e.g., for satellite clinics; presence of ethnic/religious groups and castes - e.g., for BCC activities; disaster-prone communities - e.g., for dignity kits; and geographical remoteness - e.g., for mobile RH camps. On the other hand, the evaluation team noted that CSE interventions have to date largely supported girls (and boys) within the formal education system rather than non-formal programmes for the benefit of A&Y who are not in school and generally harder to reach (A.3.3).

GBV survivors and those at risk of GBV are prominent target beneficiaries of UNFPA's work in Nepal, both in its regular programming and earthquake response, as are young women at risk of being married early – i.e., before the minimum legal age for marriage, which is now 20. The entire Outcome 2 (GE) revolves around the issues of GBV, child marriage and other harmful practises such as *chhaupadi*. Key interventions were GBV and psycho-social counselling training, support for OCMCs and safe houses and FFSs, the latter during the earthquake response. Moreover, under Outcome 1, UNFPA has advocated for and supported targeted treatment and rehabilitation services for women suffering from obstetric fistula (OF), who are underserved, and many of whom suffer from multiple vulnerabilities: they are poor, marginalized and live in isolation. As also will be seen, UNFPA has raised awareness and built capacities to safeguard the health and rights of FSWs, a particularly most at risk population group, although support has been selective and modest.

**IND1.3.4&IND1.3.5 Gender equality is at the centre of CP7 as a goal in itself and a means to an end. UNFPA has made a point to engage men and boys and other likely gatekeepers. It has applied a rights-based approach to SRH, including GBV, at programme and policy levels.**

Gender equality is an important human rights principle underlying UNFPA's corporate mandate and "bull's eye"; it is also a goal in itself. The CPE of CP6 found that UNFPA had increasingly endeavoured to mainstream gender equality.<sup>75</sup> Stakeholders interviewed during the data collection phase for the current CPE were also positive in this respect.

Within CP7 there is a separate programme component aiming to advance gender equality (Outcome 2), especially in UNFPA's priority districts. It is clearly focused on VAW and child

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<sup>71</sup> In terms of target population groups, the 2014-17 Strategic Plan calls for reaching those farthest behind by giving priority to the most vulnerable and marginalized, particularly adolescent girls, as well as to indigenous people, ethnic minorities, migrants, sex workers, persons living with HIV and persons with disabilities. Source: UNFPA SP 2014-17, p5.

<sup>72</sup> Outcome 2 of the 2014-17 SP reads as follows: "Outcome 2: Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health services". The title of the 2016 State of the World Population is "10: How Our Future Depends on a Girl at This Decisive Age".

<sup>73</sup> <http://nepal.unfpa.org/publications/national-plan-action-holistic-development-adolescents>. Only in Nepali.

<sup>74</sup> CPAP, p7.

<sup>75</sup> CPE CP6, p20.

marriage. Along with supply and demand-side interventions to increase access to SRH, improve maternal health and promote safe sexual behaviour, these are major barriers to achieving GE. Outcome 3 has played an enabling role by improving data availability and analysis for policy-making on GE and by supporting youth of both sexes to voice their needs.

At the community level, UNFPA has used structures to build networks of gender equality champions such as girls' circles/groups, women cooperatives and FCHVs. It has also strived to bring about change in discriminatory societal gender norms and attitudes among likely gatekeepers to gender equality in health. CP7 addressed gender roles and attitudes; it sensitized and built the capacities of parents, men and boys, and religious leaders as well as teachers and police officers<sup>76</sup> to be part of the solution, although in a somewhat unorganized manner.

All interviewees expressing an opinion confirmed that human rights principles and women's human rights have purposefully guided UNFPA's work in all three programme components. Document analysis confirms this finding. The UNFPA CO has consciously worked to strengthen and build the capacities of duty bearers - e.g., health and protection professionals - to provide quality services and meet their obligations. At the same time, it has reached out to and developed the capacities of rights holders - e.g., adolescent girls and youth - to make demands and to claim their rights.

As evidenced above, UNFPA programmes have targeted the marginalized and vulnerable, aiming to reduce disparities. Moreover, UNFPA has recognized young people and women as key actors in their own development, rather than only passive recipients of services and commodities. Good examples are UNFPA's support for youth participation in the earthquake response and district-level planning; empowerment of girls as peer educators through the SFSP; and training of women cooperative members as psycho-social councillors for GBV survivors and women at risk. UNFPA has not only been able to build on and further the rights of women and girls in its operational activities, but also in its upstream policy work. According to two key informants, this was facilitated by the fact that GoN representatives are generally accessible and sympathetic to UNFPA's mandate. "Choices, not chance" is UNFPA's FP slogan.<sup>77</sup> In this regard, two central achievements were highlighted by the CO, namely the 2015 National Population Policy and the 2015 Constitution where UNFPA reportedly succeeded in including new reproductive health and rights language based on the notion of choice instead of control. The FP Strategy 2020 and the costed Implementation Plan for FP 2015-20 as well as the National Health Sector Strategy 2015-21 (NHSS), developed with the support of UNFPA and other development partners, are other such accomplishments that have respected reproductive health and rights of women. Other examples of rights-based normative work can be found throughout this report.

**IND1.3.6 CP7 and the UN Development Assistance Framework are in sync except for the area of emergency response preparedness where UNFPA does not appear as a contributing agency.** As mentioned, UNFPA is expected to contribute to Outcomes 1, 3 and 5 of the Nepal UN Development Assistance Framework (UNDAF) 2013-17. CP7 results and indicators are reflected in the UNDAF Results Matrix under these outcome areas. The perception survey, conducted by UNFPA in 2013, also covered perception-based indicators in the UNDAF. The CO has participated in and led pertinent UNDAF Coordination Groups; it has fed into UNDAF Annual Reports, and helped to monitor progress.

CP7 and the UNDAF are not in sync in emergency response preparedness. Given Nepal's high vulnerability to natural disasters, UNDAF Outcome 7 envisages that people living in areas vulnerable to climate change and disasters should benefit from improved risk management and be more resilient to hazard-related shocks ("protecting development gains"). Besides a general focus of Outcome 7 on disaster risk management and climate change, Output 7.4 reads: "national preparedness and emergency systems are able to effectively prepare for and respond

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<sup>76</sup> Collaboration with the police force as part of the UNTF-funded Joint Programme "Multi-sectoral GBV Response at the District Level in Nepal".

<sup>77</sup> Choices not Chance – UNFPA Family Planning Strategy 2012-2020.

to hazard-related disasters”, which fits nicely with UNFPA’s work to prepare central and district-level partners and its target populations to cope with emergencies in the areas of GBV and RH. However, UNFPA does not appear as a contributing agency.<sup>78</sup> According to key informants, the UNDAF is very broad and agencies, for practical purposes, had to be selective.

## EQ2 Vulnerability: How did UNFPA take into account the country’s vulnerability to disasters and emergencies in planning and implementing its interventions?

### A.2.1 CP7 reflection of Nepal’s vulnerability to disasters and emergencies

#### IND2.1.1 Nepal’s high vulnerability to natural disasters and UNFPA’s actual support for emergency response preparedness are insufficiently reflected in the CPAP and its RRF.

The CPD 2013-17 starts the situation analysis by explaining that the Nepal peace process is gradually moving forward. According to the CPAP 2013-17, CP7 contributes to consolidating peace and sustaining development. Neither document discusses Nepal’s high vulnerability to natural disasters such as earthquakes, floods or landslides, or draws conclusions for UNFPA’s strategic positioning. The only references in the CPD narrative to emergency preparedness and response are in the PD programmatic area.<sup>79</sup> The CPAP is only slightly more explicit: besides planned PD-related interventions to augment data availability and increase capacities, it also lists planned SRH and GBV interventions. Only two original CPAP outputs and indicators measure UNFPA’s contribution to emergency preparedness:

- # of key sectoral ministries that have implemented their annual work plans and budgets responding to population, ASRH, youth and GBV, including in emergencies<sup>80</sup>; and
- # of UNFPA-supported districts with district contingency plans that incorporate the MISP, response to GBV and ASRH services<sup>81</sup>.

Interviewed UNFPA staff agreed that vulnerability was insufficiently reflected in CP7, especially in view of its increased prioritization by the organization today, and that CP8 should pay more attention to emergency response preparedness. They explained that no assessments or risk analyses were commissioned at the time<sup>82</sup>, but that CP7 consultations had also included humanitarian aspects. In actual fact, UNFPA has gone beyond the outputs stipulated in the CP7 RRF. *Inter alia*, the CO prepositioned RH and dignity kits as well as tents, provided diverse emergency preparedness trainings, and contributed to national and sub-national-level coordination and contingency planning.

**IND2.1.2 Based on the UNFPA-supported Post-Disaster Needs Assessment, CP7 was temporarily re-programmed after the dramatic earthquake in 2015.** Ultimately, the deadly earthquake in 2015 seems to have been an eye-opener in terms of Nepal’s vulnerabilities. UNFPA humanitarian assistance was mainstreamed. To reflect the changed situation, the RRF and certain Implementing Partner WPs were revised. New Implementing Partners – e.g., CARE Nepal<sup>83</sup> and WOREC – were contracted to help implement UNFPA’s earthquake response. CP7

<sup>78</sup> Alongside OCHA, UNICEF, OHCHR and WHO.

<sup>79</sup> CPD 2013-17, p4: “Interventions will support: (a) the development of tools and methodologies to integrate indicators on gender, youth and adolescent sexual and reproductive health, as well as humanitarian concerns, into national, sectoral and local plans and budgets; ...” (Source: CPD 2013-17, p4). “Interventions will support: (b) the strengthening of information management systems on health and gender-based violence and the sub-national capacity to use data in emergency preparedness and response; ...”.

<sup>80</sup> CPAP Outcome 3 Output 1 Indicator 1. According to the RRF, aligned with SP 2014-17 Outcome 4 Output 14.

<sup>81</sup> CPAP Outcome 3 Output 2 Indicator 1. According to the RRF, aligned with SP 2014-17 Outcome 1 Output 5 Indicator 5.2.

<sup>82</sup> A risk analysis was not mandatory according to Policy and Procedures for Development and Approval of the Country Programme Action Plan (CPAP), June 2012.

<sup>83</sup> Guided by a pre-existing global understanding between CARE International and UNFPA.

was not only re-programmed in terms of scale and types of interventions; financial and human resources were also redirected to completely different districts.<sup>84</sup>

#### A.2.2 CP7 alignment with UNFPA corporate emergency preparedness and response objectives

The UNFPA SP 2014-17 recognized the need for an expanded role for UNFPA in humanitarian settings. In 2015, the Nepal CO realigned the CP7 RRF with the SP 2014-17 IRF; later with its earthquake response.

**IND2.2.1 The re-aligned RRF is a very good reflection of the SP 2014-17 Integrated Results Framework in the area of emergency preparedness and response, but only since the 2015 earthquake.** SP 2014-17 SRH Output 5, Indicator 5.2 regarding contingency plans was already part of the original CP7 RRF. GE Output 10, Indicator 10.2 regarding inter-agency GBV coordination bodies was added during the SP 2014-17 re-alignment exercise. Alignment with the remaining pertinent IRF outputs and indicators – i.e., regarding capacities to implement MISP (Indicator 5.1), data in emergencies (Indicator 12.1), and M&E for interventions in humanitarian settings (Indicator 15.1) - only happened after the earthquake. The SP 2014-17 MTR meanwhile added four indicators to strengthen measurement and reporting in key areas of UNFPA work in the humanitarian field.<sup>85</sup> However, the evaluation team do not deem them relevant for CP7.

## 4.2 Effectiveness and Sustainability

**EQ3 SRH Services, CSE & BCC: To what extent has UNFPA contributed to sustainably improving the availability of and use of quality comprehensive SRH services, in particular for and by young people and vulnerable/marginalized women? To what extent has UNFPA contributed to increased availability of CSE and SRH/HIV BCC to promote utilization of SRH services?**

#### A.3.1 Availability and use of quality comprehensive SRH services

**IND3.1.1 UNFPA has contributed to instituting a human rights-based approach to family planning in Nepal. It can claim credit for important policy developments in midwifery and obstetric fistula.** During CP7, UNFPA technical support for the FHD was considered to have influenced the direction and emphasis of the FP Strategy 2020 and the first-ever national costed Implementation Plan for FP (2015-20).<sup>86</sup> The Strategy and Implementation Plan address existing inequities in accessing FP services and are part of a universally-accredited rights-based strategy to meeting unmet need for contraceptives instead of adopting an approach that largely defines fertility rates and choices about family size. UNFPA, along with other development partners such as UNICEF, DFID and WHO, was also a member of the team for developing the NHSS. Contrary to NHSP II, the NHSS was developed based on the principles of universal health coverage and a human rights-based approach to health. Moreover, UNFPA contributed to the revision, endorsement and dissemination of the National RH Commodity Security Strategy 2015. It provided support to FHD for conducting a study that pinpointed a lack of timely procurement of essential commodities resulting in their unavailability.

*In the area of maternal health, UNFPA's persistent advocacy resulted in having midwifery education included in the 2014 National Health Policy. Thanks to UNFPA's continuous lobbying, together with the Midwifery Society of Nepal (MIDSON), the MoH developed Midwifery*

<sup>84</sup> With the exception of Sindhuli district.

<sup>85</sup> UNFPA: Integrated midterm review and progress report on implementation of the UNFPA strategic plan, 2014-2017 - Report of the Executive Director. DP/FPA/2016/2 (Part I), 25 April 2016.

<sup>86</sup> MoHP/DoHS: National Family Planning Costed Implementation Plan 2015-2020, 2015.

Guidelines and a career ladder for midwives. In addition, UNFPA started lobbying the MoH to address the problem of obstetric fistula (OF) at the policy level and in particular to include OF screening in its basic health package. In collaboration with UNFPA, the National Health Training Centre (NHTC) and Jhpiego developed a competency-based training package on OF; the B.P. Koirala Institute of Health Sciences (BPKIHS) was accredited as a OF training site. However, as of now, stakeholders consider the allocated budget for OF inadequate.

**IND3.1.2&3.1.3&3.1.4 With UNFPA contribution, selected clinical training institutions have started to provide competency-based training to improve family planning services and reduce reproductive health morbidities. UNFPA has played a major role in promoting LARC. Health providers were satisfied with UNFPA-supported FP and RH morbidities training.** CP7 intended for UNFPA to establish four health training sites for competency-based training in FP and RH morbidities.<sup>87</sup> This target was fully achieved in collaboration with FHD and the NHTC, with technical support from Jhpiego.<sup>88</sup> At the beginning of CP7, no such training sites existed in Nepal.<sup>89</sup> The newly-established comprehensive training sites are providing advanced-level competency-based training to medical staff on different aspects related to RH and FP. UNFPA also supported and has worked through the NHTC to improve FP uptake and reduce RH morbidities – e.g., MISP and Rapid Response Team trainings – covering UNFPA priority and earthquake-affected districts.<sup>90</sup> In addition, trainings for health professionals were organized at the level of UNFPA’s 18 priority districts – e.g., on the five methods of FP (pills, condom, DPMA, implant and IUCD) and on evidence-based FP micro-planning. Interviewees particularly highlighted UNFPA support for training service providers on LARC given high demand. Monitoring data (Table 8) on FP-related trainings show that UNFPA-supported trainings on implant, IUCD, minilap, NSV and PPIUCD were received by 248, 152, 56, 26 and 16 health service providers respectively since 2014. Training data show that the number of trainees on implant increased over the years; PPIUCD was only offered in 2014. As regards RH morbidities, the number of health professionals trained on cervical cancer jumped to 91 in 2016 compared to ten each in 2014 and 2015. OF and POP trainings, using the competency-based training manual, started in 2014. The number of persons trained on SBA and ASBA so far is modest.

**Table 8: Training on FP/RH Morbidities Supported by UNFPA 2014-16**

FP training	No.
Implant	248
IUCD	152
Minilap	56
NSV	26
PPIUCD	16
Training on RH morbidities	No.
POP	121
Cervical cancer	111
OF	7
SBA	15
ASBA	4

Source: UNFPA CO, Training Data 2016

No surveys have been undertaken to ascertain trainee satisfaction with UNFPA-supported trainings. Non-representative interviews and FGDs, including with FCHVs, revealed that, overall,

<sup>87</sup> CPAP Outcome 1 Output 1 Indicator 3.

<sup>88</sup> The four comprehensive training sites are Seti Zonal Hospital, Bheri Zonal Hospital, Western Regional Hospital, and Paropakar Maternity and Women’s Hospital in Kathmandu.

<sup>89</sup> Baseline for CPAP Outcome 1 Output 1.1 Indicator 3.

<sup>90</sup> Emergency preparedness trainings are discussed more in-depth under EQ6.

training participants were satisfied with the contents of the trainings as well as with the facilitation skills of the trainers. In Sindhuli, training on insertion of IUCD and implant was considered particularly helpful for providing emergency FP services after the earthquake. Specifically for the new comprehensive training sites, a comparison of pre- and post-training test results indicates that health professionals gained knowledge from the trainings.

**IND3.1.5&3.1.6 District-level users appreciate the UNFPA-supported web-based LMIS. Its use for monitoring stock-outs has increased, but it is not fully operational, and the system is already being revamped.** It was only after the corporate shift to UNFPA's SP 2014-17<sup>91</sup> that the CO added an indicator to the CP7 RRF: "# of districts that use web-based LMIS for regular reporting for monitoring stock-out situations ...". The baseline was zero; the target was for all 18 priority districts to use the web-based Logistics Management Information System (LMIS) by the end of 2017.<sup>92</sup> According to latest monitoring data, this target has already been met. Key informants in Kathmandu recognized UNFPA's financial and technical support for transforming the paper-based LMIS to a web-based system, in collaboration with USAID. A number of interviewees confirmed that the system is being used, even if it is not fully operational.<sup>93</sup>

Evaluation team visits to district hospitals in Baitadi, Sunsari and Dang revealed that the LMIS was functional and being used. However, in Dang, irregular internet connection had regularly led to interruptions. In Sindhuli, the system had not started pending training of the DHO statistician. DHO statistical officers and storekeepers in Dang, Baitadi and Sunsari suggested that recording and reporting was user-friendly. However, while having a functioning LMIS helps monitor stock and take precautions to avert stock-out, it does not per se prevent stock-outs. There are other factors. Sunsari, for instance, benefitted from easy road access; Baitadi in the Far-west, suffered from scarcity of the popular implants in the regional medical store.

In Udayapur and Kapilvastu districts, UNFPA has also supported the Logistics Management Division (LMD) to pilot a public-private partnership for improving the supply chain using the pull system to address high stock-out situations. Outsourcing of supplies transportation at sub-district level is showing first promising results.

Meanwhile, the GoN and USAID are working on a new supply chain management programme. UNFPA is supporting this effort. The CO is supporting an online inventory system to replace the web-based system. DHO representatives in visited districts were aware of the potential benefits of online LMIS reporting versus web-based reporting system.

**IND3.1.7&3.1.8 According to the UNFPA-supported Facility-based Assessment for Reproductive Health Commodities and Services Survey, the number of service delivery points with no stock-out of contraceptives has slightly increased; on the other hand, the number of service delivery points with 7 maternal/RH medicines has significantly declined. Yet, data are not representative of UNFPA-supported districts. UNFPA has played a positive role, but other factors need to be considered such as natural disasters and restrictions on mobility. Especially implant stock-outs seem to have been an issue.** CP7 intends for UNFPA's interventions to contribute to an increased number of delivery points with no stock-out of contraceptives.<sup>94</sup> The RRF is not explicit, but, in the eyes of the evaluation team, the theory would be that UNFPA's advocacy/policy advice and technical support for the LMIS would be the main contributor to this outcome. It would also be achieved by improving the capacities of FP health service providers and, indirectly, by creating choice and generating more demand for FP contraceptives. The logic would imply that performance be tracked and measured for UNFPA's priority districts where the organization's contribution is greatest.

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<sup>91</sup> Aligned with Strategic Plan IRF Outcome 1 Output 2 Indicator 2.1.

<sup>92</sup> CPAP 2013-17 Outcome 1 Output 1.1 Indicator 5.

<sup>93</sup> The UNFPA-supported Nepal Health Facility Survey 2015 found that 94% of all facilities compiled an LMIS report (with considerable variations between the different levels). Only 61% had a designated focal person, of which only 60% had received the necessary training.

<sup>94</sup> CPAP Outcome 1 Indicator 7, added later together with Outcome 1 Output 1 Indicator 5 (LMIS).

UNFPA has indeed focused on improving the supply and demand for contraceptives, and particularly procurement and supply of LARC, mainly in UNFPA's priority districts, but also at the level of the health system: establishment of comprehensive RH training sites; FP training for health service providers; technical support for LMIS and supply chain management; central-level RH policy-making; and BCC activities.<sup>95</sup> Interviewed service providers from all four districts visited by the evaluation team informed that contraceptives had not been stocked out, with the exception of implants. Implant stock-outs were experienced because of larger than expected demand and due to interruptions in supply caused by the earthquake and southern border restrictions in 2015. None of the health facilities visited in Baitadi district had any implants because of scarcity in the regional stores.

Increasing the percentage of service delivery points that have seven life-saving maternal/RH medicines from the WHO priority list<sup>96</sup> also links back to UNFPA's involvement in supply chain management. In Baitadi, the evaluation team was informed that all life-saving maternal medicines were regularly available, except for during the border restrictions when oxytocin became scarce. However, UNFPA was able to fill the supply gap. Sunsari reported a regular supply of the seven life-saving medicines; similarly Dang.

The UNFPA-supported 2013 Facility-based Assessment for Reproductive Health Commodities and Services (FBARHCS) Survey showed that 80% of primary, secondary and tertiary service delivery points had no stock-out of contraceptives in the last 6 months.<sup>97</sup> The target was 60%, which would equal an increase in stock outs rather than a decline and is therefore not a useful benchmark. The 2015 FBARHCS Survey revealed that slightly more – i.e., 82.7% of health facilities - had no stock-out of contraceptives.<sup>98</sup> Furthermore, it indicated that 41% of health facilities had seven life-saving maternal/RH medicines. This not only clearly misses the CP7 target - i.e., 95%; it is less than the 2013 baseline of 60.7%.<sup>99</sup> However, the FBARHCS Survey only covers 15 districts of Nepal, of which only four<sup>100</sup> are UNFPA-priority districts. Data included therein therefore do not serve to assess UNFPA's performance and contribution.

**IND3.1.9 Contraceptive prevalence rate is on the increase in 11 of 18 UNFPA-supported districts. Micro-planning and satellite clinics are considered an effective approach.** Going a step further along the impact pathway, CP7 ought to contribute to an increase in the CPR, through increased and more reliable availability of and greater demand for contraceptives.<sup>101</sup> Again, the logic implies that an increase in the CPR would be greatest in UNFPA's priority districts. According to UNFPA baseline data, the CPR in 2013 was a low 43.0% nationally.<sup>102</sup> Latest UNFPA monitoring data, based on the 2014 MICS, reveal a national CPR of 49.7%, just meeting the target of 50%. Latest available official data for UNFPA priority districts (Table 9) reveal that CPR has increased against 2013 data (range 1 to 9%) in 11 districts; it has decreased in five districts.

**Table 9: Change in Contraceptive Prevalence Rate in UNFPA Priority Districts 2013-16**

Districts with Increased CPR (Increased %)	Districts with Decreased CPR (Decreased %)
Kapilvastu (5%)	Rolpa (9%)
Bajura (1%)	Pyuthan (9%)
Dang (9%)	Udayapur (5%)
Achham (4%)	Dadeldhura (3%)

<sup>95</sup> With UNFPA Implementing Partners LMD, NHTC, ADRA Nepal, FPAN.

<sup>96</sup> CPAP Outcome 1 Indicator 4. Added in context of re-alignment exercise.

<sup>97</sup> FBARHCS Survey 2013; CPAP 2013-17 RRF Outcome 1 Indicator 7 baseline data.

<sup>98</sup> FBARHCS Survey 2015; UNFPA August 2016 monitoring data.

<sup>99</sup> Sources: FBARHCS Survey 2013; FBARHCS Survey 2015; UNFPA August 2016 monitoring data. UNFPA monitoring data also indicate that 94.4% of hospitals; 85.7% of PHCCs; 53.8% of HPs; and 24.5% of SHPs had stock of seven life-saving maternal/RH medicines.

<sup>100</sup> Baitadi, Kapilvastu, Rautahat and Saptari.

<sup>101</sup> CPAP 2013-17 Outcome 1 Indicator 5. Added as part of re-alignment exercise in 2014.

<sup>102</sup> CPAP RRF Outcome 1 IND5 baseline data; baseline source: 2013 FBARHCS Survey.

Baitadi (5%)	Arghakachi (2%)
Bajhang (7%)	
Rukum (2%)	
Rautahat (5%)	
Sunsari (2%)	
Saptari (2%)	
Sindhuli (0.63%)	
Sarlahi (3%)	
Mahottari (1%)	

Source: UNFPA CO Monitoring Data (based on DoHS Data 2013-14 & 2015-16)

Besides interventions discussed above, interviewees highlighted the effectiveness of FP micro-planning for identifying VDCs with low CPR where poor, marginalized and hard-to-reach communities live and for increasing their uptake, although hard evidence still needs to be collected. UNFPA has successfully supported all its priority districts to identify VDCs or pockets with low CPR based on reviews of available data and rapid assessments where subsequently satellite clinics were organized. Main reasons provided by interviewees for decreasing CPR are lack of awareness, equipment and FP contraceptives; poor recording and use of private sector data; and high seasonal migration. Interviewees considered missing analyses of causes for low CPR problematic for future programming.

**IND3.1.10&3.1.11&3.1.12&3.1.13 UNFPA and its partners can claim credit for the introduction of midwifery education, which has just kicked off.** UNFPA considers that midwifery education is one of the unique achievements of the UNFPA country programme. Work on midwifery was carried over from CP6. CP7 envisaged a new midwifery training curriculum being taught by four training institutions by the end of 2017.<sup>103</sup> During CP7, UNFPA worked at the policy and programme level. The CO built the advocacy capacities of MIDSON to lobby with the MoH to develop a midwifery curriculum. As a result, UNFPA and MIDSON were able to support the MoH to develop a curriculum framework for Bachelor of Midwifery as per ICM-WHO standards; they advocated for the provision of midwifery education as well as for ensuring a career ladder for the midwives. Central-level stakeholders highlighted the scope of midwives to provide comprehensive maternal care and reduce maternal mortality and morbidity in future.

Three universities that run pre-service medical education, namely Kathmandu University (KU), the National Academy of Medical Science (NAMS) and BPKIHS were assessed by a joint team consisting of MIDSON, NNC, MoH and UNFPA and were found to meet minimum requirements. Their midwifery curricula were subsequently approved by the NNC. By the time of report finalization, KU had started midwifery education and NAMS had announced new admissions for Bachelor in Midwifery Sciences.

**IND3.1.14 UNFPA has contributed to successful interventions to provide targeted services for vulnerable women from low CPR pockets and for women suffering from obstetric fistula.** UNFPA staff as well as service providers from Kathmandu and the visited districts reported that UNFPA-supported SRH services have not only reached women of reproductive age in general, but that they successfully targeted poor, vulnerable and hard to reach communities, particularly those from areas with low access. For example, UNFPA focused on women from low CPR pockets for undertaking FP micro-planning. UNFPA has also supported women with OF to avail SRH services. UNFPA's contribution was prominent in providing prevention and treatment services for OF, not only to affected women from the Eastern region where the public hospital BPKIHS is situated, but to women from all over the country. Consequently, the number of women with OF seeking help has increased, from 20-25 per year on average to 50-60 annually. 350 women underwent surgery during the past five years. UNFPA recently started supporting BPKIHS to rehabilitate and reintegrate women with OF in their families and communities.

<sup>103</sup> CPAP 2013-17 Outcome 1 Output 1 Indicator 2.

**IND3.1.15<sup>15</sup>The evaluation team was unable to determine client satisfaction with UNFPA-supported SRH services. Data for assessing UNFPA’s contribution to improving the proportion of clients with demand for contraception satisfied in its priority districts are also unavailable.** Prior to the CPE, UNFPA had not gathered data on client satisfaction. Interviewed service providers and UNFPA staff claimed that clients were satisfied with UNFPA-supported SRH services. The evaluation team, however, was unable to confirm this perception with service recipients. For lack of time and availability of beneficiaries, it was unable to organize FGDs.

An expected outcome of UNFPA-supported SRH services, added as part of the re-alignment exercise, is to increase the proportion of demand for contraception satisfied.<sup>104</sup> As compared to the 2011 national baseline (65%), only one percentage point increase (66.3%) was recorded in 2014, the latest available data<sup>105</sup>, compared to the NHSS target of 72%. This is only a minor change. But available data are outdated; they do not serve to ascertain change over the period of investigation 2013-16. Furthermore, the performance indicator is positioned at the national level. Granted that UNFPA is also engaged in policy dialogue and capacity building at the national level, but the impact pathway, in the professional opinion of the evaluation team, seems too long and complex to be able to assess UNFPA’s contribution.

**3.1.16<sup>16</sup>The percentage of women aged 15 to 24 with unmet need for family planning in UNFPA-supported districts has increased.** Re-analysis of DHS data by the UNFPA CO shows that in UNFPA-supported districts the unmet need for FP among young women aged 15-24 was 36.5% in 2011. This percentage increased to 43.3% - i.e., progress decreased by six percentage points - according to a re-analysis of the 2014 MICS.<sup>106</sup> These figures also possess weaknesses: first and foremost, they are not representative of the period under investigation. Secondly, the target value included in the RRF does not differ from the baseline. It is therefore unclear against what to assess UNFPA’s performance and contribution. Looking ahead, it is worth noting that the recently introduced HMIS only collects and reports on data for the broad reproductive age group (15-49 years). Interviews conducted in the four visited districts revealed that UNFPA has contributed to addressing unmet need for FP, in particular by supporting authorities in charge to procure and supply LARC: “The greatest achievement of UNFPA lies with its support for long-acting reversible contraceptives (implants) in collaboration with DHO”, as one interviewee said. In Baitadi, a GoN pilot to integrate FP and routine immunization programmes has shown encouraging results and was recommended by a key informant for extension to other RH issues and replication in other districts.

**IND3.1.17<sup>17</sup>Half of all births to women aged 15-24 are attended by skilled birth attendants, an increase over 2011, but still comparatively low. UNFPA’s contribution was modest.** In 2011, 42% of births among women aged 15 to 24 in Nepal were attended by SBAs. In UNFPA’s 18 priority districts it was even less – i.e., an estimated 34.1%.<sup>107</sup> The target for 2017 is 60% nationally, which is yet to be achieved (50% in 2015).<sup>108</sup> The RRF does not indicate a target for the 18 districts supported by UNFPA. Official data for 2016 (Table 10) show that the percentage of births attended by SBAs have increased in 12 districts (range 1.5% to 16%) since 2013; it has decreased in five districts (range 1.5 to 16%), and remained stagnant in the remaining district.

**Table 10: Change in % of Births Attended by SBAs in UNFPA Priority Districts 2013-16**

Districts with Increased SBA (Increased %)	Districts with Decreased SBA (Decreased %)	SBA Rate Stagnant
Rautahat (10%)	Arghakachi (3%)	Sarlahi (33%)
Pyuthan (6%)	Kapilvastu (3%)	

<sup>104</sup> CPAP 2013-17 Outcome 1 Indicator 6.

<sup>105</sup> MICS 2014; UNFPA August 2016 monitoring data.

<sup>106</sup> CPAP 2013-17 Outcome 1 Indicator 1. UNFPA CO August 2016 monitoring data.

<sup>107</sup> CPAP 2013-17 Outcome 1 Indicator 2. 2011 DHS; UNFPA re-analysis of 2011 DHS.

<sup>108</sup> DoHS, Annual Report 2015.

Rukum (5.5%)	Rolpa (1.5%)	
Sunsari (4%)	Saptari (16%)	
Dang (1.5%)	Mahottari (6%)	
Bajura (15%)		
Baitadi (11%)		
Dadeldhura (12%)		
Achham (14%)		
Bajhang (16%)		
Sindhuli (2%)		
Udayapur (5%)		

Source: UNFPA CO Monitoring Data based on DoHS Data 2013-14 & 2015-16

UNFPA's support for assisted delivery has been manifold, including support for SBA trainings; orientations for FCHVs, mothers and pregnant women; and BCC on pregnancy danger signs. However, coverage was limited. Only few health service providers were trained (IND3.1.3) and IEC/BCC activities were somewhat scattered (IND3.3.5).

**IND3.1.18 UNFPA-supported institutions and SRH services are sustainable.** UNFPA has supported its central and district-level partners in the health sector to strengthen their capacity through knowledge, skills and resources; to build ownership and strengthen national systems; and to implement SRH services at the district level. It has provided support in areas where the GoN had no or limited capacity. Sustainability of comprehensive training sites, services for OF patients, supply chain management and midwifery education is likely, but remains to be seen throughout the remainder of CP7 and the next programme cycle.

#### A.3.2 Adolescent-friendly health services

**IND3.2.1 The "Barrier Study" has clearly influenced national commitments and quality standards in the area of adolescent sexual and reproductive health.** While continuing to support the implementation of the NHSP II 2010-15 and the 2010 National Adolescent Sexual and Reproductive Health Programme, UNFPA, together with UNICEF, and in collaboration with the FHD, conducted a national-level assessment of supply- and demand-side constraints to providing and utilizing quality AFHS. The recommendations of the 2015 "Barrier Study"<sup>109</sup> prompted the GoN to review existing certification criteria for the rising number<sup>110</sup> of public AFHS centres and to revise the national ASRH training package for health service providers.<sup>111</sup>

**IND3.1.2&3.1.3 Thanks to collaboration between UNFPA and the government, more and more health service providers are being trained on ASRH at six government-certified clinical training sites, surpassing the target of four sites. Training sites are providing competency-based ASRH trainings based on a revised and clearly relevant and imminently-effective training package.** During 2015-16, UNFPA supported the FHD and NHTC to establish ASRH training sites at six government hospitals across Nepal.<sup>112</sup> Based on the same model, a 7<sup>th</sup> training site is reportedly planned by NHTC in Pokhara in Kaski district, with support from Save the Children. Certification of the six training sites happened based on a jointly-developed and implemented five-step standardized process, including quality assessment, whole-site orientation, availability of master trainers, and existence of an on-site

<sup>109</sup> "Assessing Supply Side Constraints Affecting the Quality of Adolescent Friendly Services (AFS) and the Barriers for Service Utilization", January 2015. Also see Policy Brief prepared by UNFPA, UNICEF and FHD.

<sup>110</sup> 1,000 AFHS centres were established in health facilities by the end of 2015. Barrier Study Policy Brief; Burnet Institute.

<sup>111</sup> The Barrier Study was specifically referenced by the Evaluation of UNFPA Support to Adolescents and Youth 2008-2015 as a specific example of well-utilised adolescents and youth needs assessments.

<sup>112</sup> Seti Zonal Hospital in Kailali district in the Far-west development region, Bheri Zonal Hospital in Banke district in the Mid-west, Western Regional Hospital in Kaski district in the Western development region, Paropakar Maternity and Women's Hospital in Kathmandu in the Central development region, Bharatpur Hospital in Chitwan district in the Central development region and Koshi Zonal Hospital in Sunsari district in the East.

AFHS centre for demonstration purposes. The revised ASRH training package, developed in collaboration between UNFPA, FHD and NHTC, with support from SISO Nepal, includes a trainer’s guide, a participant’s handbook and reference materials. It was endorsed by the GoN in April 2015 and officially launched through master trainer trainings in July 2015 after pre-tests in February and March. Considering findings of the “Barrier Study”, the five-day in-service trainings put a stronger emphasis on skills-building, sensitization, empathy and attitude/behaviour change for better and non-discriminatory communication and counselling of adolescents. Training data for 2013-16 indicate that 74 master trainers were instructed on the new ASRH training package.<sup>113</sup>

Under the NHSP II 2010-15, the GoN planned to establish over 1,000 AFHS centres in health facilities across Nepal; it eventually established 1,134. However, there were quality issues, including inadequately trained health service providers, as also found by the Barrier Study. Hence, as also reflected in the NHSS, CP7 emphasized certification and quality rather than support for expansion of service sites.<sup>114</sup> The scope of CP7 is to train at least three health service providers from selected AFHS centres in the 18 UNFPA priority districts as a precondition for their certification. During 2015-16, UNFPA funded the training of 755 health service providers.<sup>115</sup> The evaluation team noted that UNFPA’s initiative motivated other international development partners – i.e., UNICEF and Save the Children - apart from the MoH itself - to fund additional ASRH trainings for other planned AFHS centres from within and outside UNFPA priority districts. An analysis of pre- and post-training tests revealed an imminent knowledge improvement: While on average trainees started off with a score of less than 40%, learning had increased to above the necessary 80% by the end of the trainings. Interviewed stakeholders as well as trained health professionals in Kathmandu and the visited districts clearly acknowledged the need for and appreciated the new training methodology and contents (Box 2). Visited AFHS centres in Sunsari and Sindhuli explained that trainings were somewhat rushed and more time would have been helpful.

#### Box 2: Appreciation of UNFPA-supported ASRH Trainings

“Even service providers are unfamiliar with some ASRH issues; they are hesitant to talk about them – e.g., unwanted pregnancies. SPs need sensitizing... They were familiarized with new topics and dropped some of their shyness...” FGD in Kathmandu

“We learnt about gender issues; about the H.E.A.D.S.S assessment method for interviewing adolescents... It is now easier to deal with adolescents and to talk openly about sensitive issues... Very much appreciated” FGD in Sindhuli

Source: Evaluation Team

**IND3.2.2&3.2.3 UNFPA played a crucial role in revisiting the quality criteria and certification process for AFHS centres. Already 24 health facilities in ten UNFPA priority districts are certified AFHS centres, thanks to UNFPA, and others are in the pipeline. Certification no longer solely depends on UNFPA’s support. Making available a dedicated consultation room that ensures privacy is a practical problem.** The “Barrier Study” resulted in a review of AFHS centre standards, for which UNFPA provided technical<sup>116</sup> and financial support, and which resulted in the endorsement by FHD of a new AFHS centre quality improvement and certification tool in July 2015.<sup>117</sup> The evaluation team noted and observed that the tool was being used for certifying AFHS centres, based on health facility self-assessments and work plans, joint DHO and UNFPA pre-certification visits and joint FHD, UNFPA, DHO and ADRA certification missions (including client exit interviews). Asked about the certification criteria,

<sup>113</sup> UNFPA: Outcome 1 Training Data, received November 15<sup>th</sup> 2016.

<sup>114</sup> The ultimate goal of the National Health Sector Strategy is to scale up of adolescent-friendly services throughout the country in all approximately 4,000 public health facilities.

<sup>115</sup> Source: Manju Karmacharya: ASRH Services for Adolescent in Nepal: ASRH Training and Certification, September 2016.

<sup>116</sup> Including with the support of SISO Nepal.

<sup>117</sup> Available in Nepali only.

health officials and service providers in the visited districts and Kathmandu expressed difficulties making space available that ensures privacy and confidentiality.



**AFHS Centre Beneficiaries in Sindhuli District**

At the time of evaluation data gathering, three UNFPA-supported AFHS centres in Sindhuli district, two in Pyuthan, two in Achham, two in Bajhang and two in Sunsari had been certified.<sup>118</sup> By the end of November 2016, an additional 13 had joined the group.<sup>119</sup> While the RRF target of at least one certified centre per UNFPA priority district has not yet been met, interviewees were satisfied with progress made within not quite 12 months and confident that the

target will be met by the end of CP7.<sup>120</sup> Moreover, health facilities have been certified without UNFPA's direct involvement – i.e., in Kapilvastu supported by Save the Children, and this number is also expected to grow given the additional support from other international development partners for the AFHS programme and from the GoN budget.

**IND3.2.5&3.2.6 The number of adolescents utilizing the services of AFHS centres in UNFPA-supported districts has increased since 2014, but coverage of the adolescent population remains low. More publicity would help. IEC/BCC materials play a crucial role in satisfying adolescents' information needs.** In 2014, UNFPA reported that 102,302 adolescents aged 10-19 had utilized ASRH services in ten UNFPA-supported districts, corresponding to approximately 10% of the total adolescent population of 982,695. This figure increased to 300,476 in eleven districts in 2015; it increased further to 350,752 in 18 districts in 2016. Data are disaggregated by gender: In 2015, 159,876 male and 140,600 female; in 2016, 166,917 male and 350,752 female. UNFPA monitoring provides no further breakdown. Interviews in Baitadi, Sunsari and Sindhuli confirmed that the number of visits to AFHS centres was increasing, and that more girls than boys were seeking counselling and services. While in Baitadi most clients were reportedly already married, this was not the case in Sunsari and Sindhuli. Asked about very young adolescents, the evaluation team was informed that only very few were below the age of 14; the majority were around 15-16. As one interviewee said: "they do not yet understand sexuality... they have not yet started experiencing changes".

More publicity for AFHS centres would be important for greater uptake as remarked by several interviewees. A number of conversations pinpointed that knowledge about and familiarity with AFHS centres were insufficient: among adolescents, among particularly vulnerable adolescents, and among officials and service providers outside the health sector. Visiting nearby schools, promoting ASRH services through FCHVs, participating in girls' circles, and inviting district-level DEO and WCO officials and teachers to see AFHS centres with their own eyes were mentioned as good outreach examples.

The evaluation team was able to conduct two FGDs with AFHS clients. One group of around ten school-going, unmarried girls between the age of 12 and 16 was very satisfied with information and services received, which they claimed had improved over the last 12 months. They were particularly keen to visit the centre to read and discuss the set of eight IEC booklets on issues related to adolescents' SRH and rights produced and distributed earlier by UNFPA, GIZ, NHEICC and the Nepal Red Cross Society (NRCS) through UNFPA. Concerned service providers in all visited districts requested for more and new IEC/BCC materials - both print and multi-media.

<sup>118</sup> CO monitoring data September 26<sup>th</sup> 2016.

<sup>119</sup> Kapilvastu (2), Mahottari (2), Rautahat (3), Rukum (3), and Sarlahi (3). Plus one AFHS centre in Kapilvastu supported through Save the Children.

<sup>120</sup> Three more districts (Baitadi, Bajhang and Arghakanchi) are in the pipeline for certification in December 2016.

**IND3.2.4 Recording, reporting and analysis of ASRH service utilization data is a bottleneck to effective planning, monitoring and decision-making, especially the revised HMIS.** Health facilities are expected to record visits by adolescents and report to the district-level DHO on a monthly basis for onward transfer to the MoH and the HMIS. Monthly reporting is not yet the norm. Moreover, observations revealed different - manual - recording formats as concerns age groups, gender, marital status, in- or out-of-school, and types of services. The evaluation team noted that ultimately the revised HMIS does not capture ASRH services as a separate programme component, and that it only offers data for the broad age cohort 15-49. This renders any planning, monitoring and decision-taking difficult, if not impossible, for the 10-19 year olds, or even 10-14 (early adolescence) and 15-19 (late adolescence) year olds.

**IND3.2.7 Political commitments are considerable, but sustaining quality and taking certified AFHS centres to scale will require extra efforts.** As already seen, adolescents' health, including SRH, has been increasingly reflected in GoN policies and programmes over recent years, and political commitments are considerable. The "Barrier Study" provided an additional push. This bodes well for the future of ASRH trainings and certification of AFHS centres. However, according to several interviewees in Kathmandu and the visited districts, money could well be an issue for sustaining benefits and taking the programme to the planned ambitious scale, despite "Red Book" government and donor - including UNFPA, UNICEF and Save the Children - funding.

As one key informant said: "AFHS centres are not certified for ever": One area of concern arising from interviews is how to assure the quality of AFHS centres after their certification. Quality criteria are available and quality assurance mechanisms in place at health facility (HFOMCs) and district (DHO) levels. However, some stakeholders fear lack of capacity and funds for serious monitoring and follow-up of an increasing number of AFHS centres.

### A.3.3 Comprehensive sexuality education

**IND3.3.1 Although not directly engaging in the education sector, UNFPA successfully pushed for inclusion of CSE in the Nepal School Sector Development Plan 2016/17-2022/23.** Under CP5 and CP6, UNFPA had supported various ASRH IEC activities as part of its efforts to further sexuality education and HIV prevention. Taking the organization's engagement a step further, CP7 committed UNFPA to support the review and revision of the existing CSE curriculum to make it age-appropriate and gender-sensitive.<sup>121</sup> In 2013, the CO initiated a review of the formal school curricula (grades 1 to 10), teacher training curricula as well as non-formal curricula and training materials to identify gaps in sexuality education content and delivery. It did so against the UNESCO 2009 International Technical Guidelines on Sexuality Education.<sup>122</sup> A "Comprehensive Sexuality Education Review" was published in 2014.<sup>123</sup> A Policy Brief<sup>124</sup> was developed and used, with UNICEF support, for advocacy vis-à-vis the MoE and education sector partners as well as parliamentarians. With some delay because of the earthquake, a CSE technical working group was formed with the participation of the three concerned MoE departments<sup>125</sup>; work plans for strengthening CSE were developed. According to UNFPA staff, it is also thanks to UNFPA analysis and advocacy that the School Sector

<sup>121</sup> CPAP 2013-17, p10.

<sup>122</sup> UNESCO: International Technical Guidance on Sexuality Education – An evidence-informed approach for schools, teachers and health educators – Volume I: The rationale for sexuality education, December 2009.

<sup>123</sup> "Review of Curricula in the Context of Comprehensive Sexuality Education in Nepal – A Review of Formal Curricula (Grade 1-10), Non-formal Curricula, Teacher's Training Curricula (Pre and In-service) and Training Materials in Line with Comprehensive Sexuality Education against UNESCO 2009 International Technical Guidelines on Sexuality Education (ITGSE)-II", August 2014.

<sup>124</sup> UNFPA/MoE: Review of Curricula in the Context of Comprehensive Sexuality Education (CSE) in Nepal, 2014.

<sup>125</sup> Curriculum Development Centre (CDC); National Centre for Education and Development (NCED); Non-formal Education Centre (NFEC).

Development Plan 2016/17-2022/23<sup>126</sup>, the GoN's major education initiative, includes CSE under result 2.2.1: “% of schools that provide life skills-based health and sexuality education”.

**IND3.3.2&3.3.3 UNFPA is on track to strengthen the inclusion of CSE topics in grades 1 to 10. However, subordinate to formal curriculum review cycles, it will not completely achieve its objectives for CP7.** UNFPA CSE interventions under CP7 Outcome 1 took off with the “CSE Review” mentioned above.<sup>127</sup> CSE interventions have been implemented along several tracks. At the institutional level, the only expected output included in the RRF is Output 1.1 Indicator 3, which was added in the context of re-alignment with the SP 2014-17. It reads as follows: “National CSE curricula are in place aligned with international standards (ITGSE)”. The baseline was determined to be zero.<sup>128</sup>

By the end of CP7 in 2017, UNFPA expected to have supported the inclusion of CSE in the curricula for school grades 1 to 10 and the associated text books and teacher training manuals. Work is ongoing. At the time of evaluation data collection, the Curriculum Development Centre (CDC) had strengthened the comprehensiveness of sexuality education for 9<sup>th</sup> and 10<sup>th</sup> graders (secondary education). For lack of time, the evaluation team was not in a position to assess how well CSE topics have been strengthened and are aligned with international standards. UNFPA had provided three-day CSE training for 15 MoE officials, teachers and text book writers.<sup>129</sup> As for the other grades, UNFPA is expected to be involved during the 2017 in reviewing CSE revision cycle in primary education (grades 1-3, 4 and 5). Given CDC's new responsibility for grades 11 and 12 (higher secondary education), new opportunities for collaboration may arise.

**IND3.3.2 Seeking greater scale, UNFPA is supporting the Ministry of Education to include CSE teacher training in its regular in-service training programme. UNFPA also supported the design of and is helping to implement a joint MoH/MoE menstrual hygiene management strategy.** In CP5, UNFPA provided modest support to build the capacities of teachers in its priority districts to talk to students about ASRH. In the absence of in-service CSE training for teachers it has continued to do so under CP7. DEO interviewees in the four visited districts were satisfied with UNFPA-sponsored teacher trainings and requested greater coverage. However, hesitance to teach comprehensive sexuality education in schools is still a major concern and remains a systemic challenge. Consequently, besides following up on recommendations to improve and make more comprehensive the school sexuality education content, UNFPA recently started to partner with the GoN to improve sexuality education delivery throughout the country's public schools. With funding from the Government of Australia and in collaboration with the National Centre for Education and Development (NCED), UNFPA through SISO Nepal is supporting the development of an in-service CSE teacher training package, with technical oversight by the CSE technical working group. At the time of evaluation data gathering, SISO was preparing a 1<sup>st</sup> draft of the training package and resource materials, which were expected to be available for MoE endorsement by December 2016.

The menstruation cycle and menstruation hygiene is part of CSE and a learning objective for adolescents aged 9 and upwards.<sup>130</sup> UNFPA provided technical support for elaborating and, starting in 2016, implementing a joint MoH/MoE menstrual hygiene management strategy and training package. With funding from the Australian Government, SISO has started to conduct menstrual hygiene management trainings for selected education and health professionals in five UNFPA priority districts.<sup>131</sup>

<sup>126</sup> <http://www.moe.gov.np/article/535/school-sector-development-plan.html>. SSDP exists in Nepali only.

<sup>127</sup> Outcome 1 in fact does not use the term “comprehensive sexuality education”, but “sexuality education”.

<sup>128</sup> August 2016 monitoring data.

<sup>129</sup> The evaluation team was unable to assess trainee satisfaction (evaluation matrix **IND3.3.3**: Trainee satisfaction with CSE curricula and capacity building). Only one trainee was interviewed who was “happy” with the knowledge, information and CSE materials received.

<sup>130</sup> UNESCO: International Technical Guidance on Sexuality Education – An evidence-informed approach for schools, teachers and health educators – Volume I: The rationale for sexuality education, December 2009.

<sup>131</sup> Sindhuli, Udaipur, Bajang, Baitadi and Rukum districts.

**IND3.3.2 Students-teachers-parents dialogue; health worker visits to school classes; and adolescent information corners in schools are complementary and welcome ways to strengthen CSE in school settings.** UNFPA and district-level partners have explored and are exploring other ways to promote and support CSE in school settings. In Baitadi and Dang, for instance, UNFPA support for dialogue between students, teachers and parents on ASRH topics was found to be very relevant and much appreciated. Equally, interviewees in Baitadi, Sunsari and Sindhuli districts were largely in favour of health worker outreach and visits to school classes, thus linking up the education and health sectors. In Sindhuli, the DEO organized ASRH orientations for secondary school girl students, for teacher/parent associations and school management committees, and eventually for boys, after realizing they were being neglected. Moreover, at the time of data collection, the establishment of adolescent information corners in schools were planned under the Australian-funded project as well as under the even more recent UNESCO/UNFPA/UN Women joint programme “Empowering Adolescent Girls and Young Women through the Provision of CSE and a Safe Learning Environment in Nepal”.<sup>132</sup>

**IND3.3.2&3.3.4 UNFPA facilitated policy recommendations for improving CSE for out-of-school adolescents and youth. Until now, while not excluding out-of-school young people as beneficiaries, the organization has not targeted their specific SRH information and education needs. Plans are in the making.** CP7



**CSE School Girl Beneficiaries in Baitadi District**

committed UNFPA to “mobilize peer educators for message dissemination on STI and HIV/AIDS to adolescents and youth, including unmarried, out-of-school adolescents and FSWs”; furthermore to “support government to assess, refine and strengthen the out-of-school/adolescents’ life skills programmes”.<sup>133</sup> The “CSE Review”, led by UNFPA, discussed non-formal CSE for out-of-school adolescents and youth. It recommended aligning the MoE Non-Formal Education Centre (NFEC) “Flexible Schooling Programme” with the formal school curriculum cycles and CSE revisions as per ITGSE standards, as well as ensuring that out-of-school children benefit from Rupantaran.<sup>134</sup>

Rupantaran is implemented in informal settings. Its design was led by UNICEF with the support of UNFPA and others to help implement the National Plan of Action for the Holistic Development of Adolescents, in itself a collective effort. UNFPA was instrumental in designing the GBV and SRH modules. The final package is being used by the MoWCSW and MoYS. Rupantaran cuts across and contributes to both the CP7 SRH and GE programme components. To date, UNFPA has gathered experience with Rupantaran in the GE component for the benefit of girls’ circle/group members, without differentiating between in- and out-of-school girls. Looking ahead, UNFPA also plans to use the package in a comprehensive manner in its ASRH programme, as part of the Joint Programme “Empowering Adolescent Girls and Young Women through the Provision of CSE and a Safe Learning Environment” and in the Australia-funded project where, together with the NFEC<sup>135</sup> and Restless Development, it intends to introduce Rupantaran specifically for out-of-school education in early 2017. The evaluation team was also informed about a soon-to-be-launched mobile app on ASRH.

**IND3.3.7 Education sector CSE will continue to depend on external advocacy, technical support and funding for the near future.** As revealed above, CSE is now anchored in the

<sup>132</sup> This five-year joint programme, funded by KOICA, will be implemented in five UNFPA priority districts (Saptari, Sunsari, Sarlahi, Rautat) with a total budget of \$5m (UNFPA: \$500,000).

<sup>133</sup> CPAP 2013-17, p10 & p12.

<sup>134</sup> “CSE Review” policy brief.

<sup>135</sup> The evaluation team was unable to meet NFEC representatives.

School Sector Development Plan 2016/17-2022/23; it is gradually strengthening its positioning within the formal school curriculum and should be included in national teacher training. However, CSE with its six components is a new concept, it is not considered a top priority<sup>136</sup>, and dedicated domestic funding is insufficient.<sup>137</sup> Frequent government staff rotation has impeded national ownership. As one key informant said: “CSE is still very new ... would die if external support were to be discontinued”.

#### A.3.3 SRH/HIV information, education and behaviour change communication

UNFPA IEC/BCC activities and trainings have cut across CP7 Outcomes 1 (SRH) and 2 (GE), contributing to RRF outputs 1.2, 2.2 and 2.3. Activities have revolved around the issues of pregnancy complications, HIV, GBV and child marriage in an attempt to contribute to improved health and well-being of women, mothers and adolescent girls by informing, educating and promoting positive behaviours appropriate to community settings. In addition, HIV outreach work has targeted FSWs.<sup>138</sup> Activities, in collaboration with the National Health Education, Information and Communication Centre (NHEICC), DDCs and district line agencies, as well as other partners have been manifold. The evaluation team was unable to grasp or map them all.

Although at times difficult to disentangle, this section speaks to SRH/HIV outreach under Outcome 1. UNFPA outreach in the areas of GBV and child marriage is discussed under EQ4.

**IND3.3.5 UNFPA and the NHEICC have moved away from somewhat scattered IEC/BCC activities in support of Outcome 1 objectives to a programmatic approach that promises greater effectiveness. Print materials and tools were not sufficiently available to satisfy needs.** As part of its regular programming, the UNFPA CO has supported the airing of radio and TV PSAs, dramas and talk shows across all Nepali districts. It has invested additional resources in its priority districts. The evaluation team was able to interview two representatives of local FM radios, with whom UNFPA collaborated to air jingles and mini-dramas, including after the earthquake. It enquired with other stakeholders and beneficiaries about the value added of FM broadcasting for disseminating information and messages. Reactions were all favourable. Wide population coverage and the importance of FM radio in the absence of the internet were mentioned as pluses. It was suggested that FM radio could be used to increase knowledge about newly-introduced health services such as OCMCs and AFHS centres. UNFPA has also supported the production of print materials and communication tools and organized orientations and trainings. Interviewed SRH stakeholders and beneficiaries very much appreciated the production of such materials, but worried that they were not sufficiently available to satisfy their needs. This was also observed by the evaluation team. Another main message conveyed to the team was the importance of localizing broadcasting and other types of IEC/BCC activities: local stories; locally-adapted messages; and local languages.

One key informant lauded UNFPA’s expertise and clear understanding of the subject matters, but regretted that only little funding was available compared to needs, limiting UNFPA’s contribution. Stakeholder opinions generally seemed to differ on whether to continue using limited funding to cover as much ground as possible, even if somewhat superficially, or whether to concentrate and target particular geographical areas. Another aspect that has potentially affected UNFPA’s effectiveness and contribution to changes in attitudes and behaviours relates to coordination: first between the centre and districts; second between different ministries. As it seems, interventions in UNFPA-supported districts have been implemented in an uncoordinated manner, especially without involvement from the centre. Furthermore, it was realized that better collaboration between UNFPA’s GoN partners in charge of informing and educating A&Y - i.e., MoH, MoE, MoWCSW and MoFALD, could have produced valuable synergies.

<sup>136</sup> Stakeholders mentioned lack of vocational skills as well as teacher and student absenteeism as burning issues.

<sup>137</sup> There is no separate budget line for CSE in the “Red Book”; rather, it is included in the curriculum as part of the regular teaching learning process.

<sup>138</sup> Discussed further below as separate aspect of CP7.

In early 2016, UNFPA and the NHEICC agreed upon a two-year BCC Strategy and Implementation Plan for 2016-17 with a total estimated budget of approximately \$1.9m.<sup>139</sup> Implementation at national and district level has started, with some months' delay.<sup>140</sup> Six inter-related issues were identified based on data and a bottom-up consultation process, again covering both CP7 Outcomes 1 and 2: pregnancy danger signs; HIV; condom use among male clients of FSWs; access to care following sexual violence; violence against women and girls; delay marriage until age 20. A communication mix consisting of radio and TV PSAs, billboards and posters, inter-personal communication tools, IEC give-aways, capacity building, and community mobilization activities was chosen. A good attempt was made to develop process and outcome indicators and monitoring methodologies.

**IND3.3.5 UNFPA has raised awareness and built capacities to safeguard the health and rights of female sex workers, going beyond HIV prevention and access to SRH services, but support and UNFPA's contribution to change has been modest.** CP7 aims to increase the knowledge of FSWs in UNFPA priority districts about HIV prevention, increase condom use with clients, and facilitate access to SRH and HIV services. To measure the organization's performance, the RRF included the outcome-level indicator “% of FSWs in UNFPA-supported districts reporting the use of a condom with their most recent client”.<sup>141</sup>

UNFPA work with and for FSWs was carried over from CP6 when UNFPA supported the GoN to develop a toolkit for HIV prevention in sex-work settings and supported capacity building for FSW networks.<sup>142</sup> Under CP7, support has been modest in monetary terms; it was limited to only few districts.<sup>143</sup> Explanations provided by key informants for this decision were that not a significant number of UNFPA priority districts fall in the HIV epidemic zones of Nepal as declared by the GoN; that other partners were more invested; that HIV prevalence among FSWs as per 2015 estimate remains at 2% only; and that other issues must enjoy greater priority. Activities were implemented with support from FPAN and JMMS. They went beyond HIV prevention to address SRH and GBV and included research and analysis<sup>144</sup>; campaigns and dissemination of IEC/BCC messages; training for district officials and service providers; training of FSWs as peer educators; training for FSWs; inter-actions between FSWs and service providers; and vocational skills training for FSWs.

In 2012-13 UNFPA estimated the percentage of FSWs in UNFPA-supported districts having used a condom with their most recent client to be 64.5%.<sup>145</sup> The GoN national target for 2017 was set at 80%.<sup>146</sup> Latest monitoring data reveal that 85.5% of FSWs reported having used a condom with their most recent client in 2015. However, this figure is not meaningful since it relates to street-based FSWs in Kathmandu Valley<sup>147</sup> and not districts with UNFPA interventions. Even if it were, the evaluation team, based on evidence collected and analysed above, would hesitate to attribute a major contribution to UNFPA.

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<sup>139</sup> “Creating Courage for Change in Nepal – A Comprehensive Behaviour Change Communication Strategic Implementation Plan”, June 2015. “Creating Courage for Change (CCC) – A Behaviour Change Intervention of GoN/UNFPA 7<sup>th</sup> CPAP – Behaviour Change Communication (BCC) Materials Prototypes and Costed Implementation Plan and Monitoring Framework”, February 2016.

<sup>140</sup> First activities were envisaged for February/March 2016 according to the Implementation Plan.

<sup>141</sup> CPAP 2013-17 Outcome 2 Indicator 3.

<sup>142</sup> CPE CP6, p24 & p45.

<sup>143</sup> E.g., Sindhuli, Dang, Sunsari, Sarlahi, Pokhara, Baitadi, Kapilvastu, Saptari, Mahottari.

<sup>144</sup> E.g., JMMS involvement during 2013 and 2014 in regional study entitled “Sex Work, Violence and HIV in Asia – from Evidence to Safety”.

<sup>145</sup> Based on national-level data. In 2013, FSW Terai highway districts Integrated Bio-Behavioural Surveillance Survey (IBBS) data was 75%. The GoN target for condom use was 80%. UNFPA further analysed the 2013 IBBS data for UNFPA-supported districts and the target was set at 64.5%.

<sup>146</sup> National HIV Strategic Plan target. UNFPA did not set a target for its priority districts.

<sup>147</sup> UNFPA August 2016 monitoring data. IBBS Round V – 2015: Integrated Biological and Behavioural Surveillance (IBBS) Survey among Female Sex Workers (FSWs) in Kathmandu Valley.

The evaluation team was able to consult with beneficiary FSWs in Sunsari and Dang districts who were appreciative of UNFPA's engagement and suggested that more support was required, including refresher trainings, reaching out to "hidden" sex workers, facilitating unbiased access to (adolescent-friendly) health and GBV services, sensitizing police officers, and offering alternative income generation activities. The above-mentioned UNFPA/NHEICC BCC Strategy and Implementation Plan for 2016-17 envisages activities for increasing condom use among FSWs and their clients across all UNFPA-supported districts; it noted the need to primarily change the behaviours of FSW clients and their husbands/regular partners. Looking further ahead, interviewed stakeholders agreed that FSWs are vulnerable to HIV and violence; that they are discriminated against; that protecting and empowering FSWs was not a government priority; and that UNFPA could have a role to play during CP8. However, given limited and increasingly earmarked UNFPA resources, the comparatively low and decreasing prevalence rate among FSWs as a key HIV population<sup>148</sup>, and major HIV/AIDS funding from other donors<sup>149</sup>, its particular niche was not immediately evident.

**EQ4 GBV and harmful practices: To what extent has UNFPA contributed to improving the availability of and access to quality GBV services in a sustainable manner? To what extent has it contributed to preventing GBV, child marriage and other discriminating and harmful practices?**

#### A.4.1 Strengthened health system response to GBV

**IND4.1.1 UNFPA's contribution to the legal, policy and programme framework regarding GBV and ending child marriage is evident. The Clinical Protocol on GBV, the National Strategy on Ending Child Marriage and "Rupantaran" are three such highlights.** During CP7, UNFPA has worked in close collaboration with the GoN and other partners to develop national strategies on GBV and child marriage. With UNFPA technical and financial assistance, and with the support of Jhpiego, a Clinical Protocol on Gender-based Violence was developed by the MoH and endorsed by the GoN in 2015. The protocol is the first national guideline for health care providers on GBV management in Nepal. Based on the protocol, a competency-based training package was developed with UNFPA's support under the leadership of the NHTC.<sup>150</sup>

Furthermore, UNFPA and the Centre for Reproductive Rights (CRR) have co-operated closely to promote a legal policy framework that aligns with Nepal's commitments as regards child marriage. Based on CRR research in South Asia<sup>151</sup>, a briefing paper with recommendations for legal reforms to strengthen protection against child marriage and accountability for violations of national laws that prohibit child marriage was published. In collaboration with UNICEF, UNFPA also actively participated in the National Steering Committee for developing a National Strategy on Ending Child Marriage 2015.

In line with the National Plan of Action for the Holistic Development of Adolescents, UNFPA supported UNICEF to develop, test and finalize the SFSP for adolescents, also called "Rupantaran", which includes, *inter alia*, modules on GBV, child marriage and other harmful practices. Rupantaran is now a government-owned training package: it was endorsed by the MoWCSW and MoYS. According to the UNFPA CO, it should also be implemented through the President's Programme to Empower Women and Girls that was launched during the Nepal Girl Summit in March 2016.

<sup>148</sup> EPI Fact Sheet 1 2014: FSWs prevalence rate 2%; EPI Fact Sheet 2013: FSWs prevalence rate 2%.

<sup>149</sup> Japan, the Global Fund and USAID were mentioned.

<sup>150</sup> <http://nepal.unfpa.org/publications/clinical-protocol-gender-based-violence>. Only available in Nepali.

<sup>151</sup> [https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/ChildMarriage\\_BriefingPaper\\_Web.pdf](https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/ChildMarriage_BriefingPaper_Web.pdf).

IND4.1.2&4.1.3 UNFPA has contributed to better quality public health services for GBV survivors, but so far mainly only in six districts. UNFPA has not only supported the health response to GBV. Referral services have been strengthened, but observed safe houses faced problems. Trained service providers were generally satisfied. Since 2011, the MoH has established 21 One-stop Crisis Management Centres (OCMCs) for GBV survivors in public hospitals across Nepal in districts that have safe homes for GBV survivors.<sup>152</sup> During 2013-16 UNFPA has supported OCMCs, along with DFID and WHO. CP7 committed UNFPA to work with the GoN to increase the number of OCMCs that comply with MoH guidelines from a baseline of zero to one each in ten of its priority districts.<sup>153</sup> This target was increased to one public sector hospital in each of UNFPA's 18 programme districts. This target is not likely to be met: monitoring data reveal six OCMCs in UNFPA priority districts that are considered to be applying MoH guidelines – i.e., in Dang, Pyuthan, Rautahat, Saptari, Sarlahi and Sunsari.



OCMC at the Centre of the GBV Referral System

UNFPA support for OCMCs has been manifold: it began with an assessment<sup>154</sup> of existing OCMCs in 2013 in collaboration with the MoH and DFID. The assessment revealed a need to develop the capacities of health service providers working at OCMCs to respond to GBV and to enhance referral mechanisms.<sup>155</sup> It found a clear consensus among central and district-level stakeholders, as well as among GBV survivors themselves and their families,

that OCMCs are a worthwhile and positive government-led initiative.<sup>156</sup> Consequently, UNFPA supported two annual review meetings, 14 days of medico-legal training for selected OCMC doctors, six months' training for selected OCMC focal points/staff nurses on psycho-social counselling, training of 102 health service providers in the OCMCs in Dang, Sarlahi, Sunsari and Pyuthan on GBV and clinical management of rape (CMR)<sup>157</sup>, provision of post-rape treatment kits (Kit 3) to all OCMCs for delivering regular services, and an observation visit to Sri Lanka for MoH, OPMCM<sup>158</sup> and Department of Women and Children (DWC) staff.

The evaluation team visited the OCMCs in Sunsari and Dang districts. It observed that they were working well. They provided an integrated package of services for GBV survivors and followed the core principles of ensuring the security and safety of GBV survivors, maintaining case confidentiality, and respecting the dignity, rights and wishes of survivors. The visited OCMCs have reportedly referred survivors to other hospitals for advanced treatment, to safe homes under the responsibility of WCOs<sup>159</sup>, to the police for prosecuting cases, and to NGOs for rehabilitation and livelihood-related skills training; they also put survivors in contact with lawyers. The dedication and interest of trained OCMC focal persons were clearly evident. The Auxiliary Nurse Midwife (ANM) in Sunsari had been awarded the Best Counsellor Award from the CDO as recognition of her services. Likewise, in Dang, the ANM has been awarded several

<sup>152</sup> Established 2011/12: Makwanpur, Kanchanpur, Doti, Panchthar, Baglung, Sunsari (UNFPA priority district), Bardiya; 2012/13: Kathmandu, Tanahun, Nawalparasi, Dang (UNFPA priority district), Solukhumbu, Sarlahi (UNFPA priority district), Saptari (UNFPA priority district), Kabhre Palanchowk; 2013/14: Jumla; 2015/16: Pyuthan (UNFPA priority district), Rautahat (UNFPA priority district). GoN/NHSSP and UKAID: INNOVATIVE GOOD PRACTICES IN NEPAL'S HEALTH SECTOR 3. Hospital-based One-Stop Crisis Management Centres, February 2016; [http://www.nhssp.org.np/pulse/Pulse\\_OCMC\\_good\\_practices\\_february2016.pdf](http://www.nhssp.org.np/pulse/Pulse_OCMC_good_practices_february2016.pdf).

<sup>153</sup> CPAP 2013-17 Outcome 2 Output 1 Indicator 1. At the time, four OCMCs already existed, but were not considered to comply with the MoH guidelines.

<sup>154</sup> MoH: Assessment of the Performance of Hospital-Based One Stop Crisis Management Centres, 2013.

<sup>155</sup> Assessment of the Performance of the Hospital-based OCMCs. Population Division, MoHP.

<sup>156</sup> MoH: Assessment of the Performance of Hospital-Based One Stop Crisis Management Centres, 2013.

<sup>157</sup> Outcome 2- training compiled by UNFPA, November 2016. OCMCs in Pyuthan and Rautahat were set up in 2015/16.

<sup>158</sup> Office of the Prime Minister and Council of Ministers.

<sup>159</sup> Generally run on their behalf by women's cooperatives.

times in appreciation for her work. The ANMs suggested that they required refresher trainings on GBV and recommended that all doctors and nurses should be trained on post-rape treatment. Other health service providers consulted by the evaluation team reported high satisfaction with trainings received from the NHTC through the Centre for Victims of Torture Nepal (CVICT). They appreciated that clinical and practical training used an on-the-job training approach to focus specifically on competencies. Instead of relying on the traditional way of training where participants are simply given knowledge, this novel training model helped them to acquire skills through interactive methods that encouraged dialogue, discussion and learning by doing. Likewise, health care providers in Baitadi and Sunsari attended training on psycho-social counselling and orientation regarding GBV and multi-sectoral services. With regards to counselling training, they stated their satisfaction. However, staff in Baitadi specified that the orientation on GBV and multi-sectoral services and referral was too short. It was suggested that refresher and upgraded training would be beneficial to work better.

UNFPA's support for GBV survivors and vulnerable women and girls has gone beyond health service delivery. As safe houses are a national prerequisite for setting up OCMCs, and an important element of the referral system, UNFPA has also advocated for and provided limited support for the establishment and running of safe houses in a number of its priority districts – inter alia by providing logistics support and training safe house and WCO staff on GBV and psycho-social counselling.<sup>160</sup> This was not originally envisaged in the RRF. The evaluation team visited three safe houses, only one of which (Sindhuli) had received (logistics) support from UNFPA, Observation of the safe houses in Sunsari and Sindhuli gave cause for concern. In Dang, safe houses in the VDCs reportedly have limited funds and GBV survivors are often housed privately until a transfer to the district safe house becomes possible. The district safe house seemed to be running well; in 2016 it catered to 131 cases. The other two in Sunsari and Sindhuli did not appear promising. Both face financial, staffing and security problems; in the eyes of the evaluation team they were insufficiently equipped to offer survivors comfort and structure.

**IND4.1.4&4.1.5 The number of GBV survivors cared for by UNFPA-supported OCMCs differs considerably from district to district. GBV survivors seeking help from OCMCs and safe houses are overwhelmingly female.** Overall, OCMCs had provided support and services to 4,420 GBV survivors as of mid-November 2015, 94% of which were female.<sup>161</sup> GBV cases having received care in UNFPA-supported OCMCs were 300 in Dang, 18 in Pyuthan, 312 in Sunsari, 96 in Sarlahi, 632 in Saptari and 7 in Rautahat.<sup>162</sup> GBV survivors stayed in the OCMCs up to 15 days, but there is apparently no guidance as to how long they can stay. OCMCs referred cases to the safe houses when the survivors had no place to go. GBV survivors were housed in safe houses up to 45 days. Most recent data of GBV survivors receiving support in UNFPA-supported safe houses, all of whom were female, are 1,116.<sup>163</sup>

In the districts visited, the evaluation team heard that knowledge about the existence of UNFPA-supported GBV services has increased, but that it varied. The team was informed that awareness about OCMCs has grown as hospital staff, police and local government officials have been orientated on the purpose and role of OCMCs. A low level of knowledge was especially the case in distant and remote communities. Language problems were another factor affecting knowledge about GBV services. Also, GBV survivors and vulnerable women and girls were not

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<sup>160</sup> Outcome 2- training compiled by UNFPA, November 2016. UNFPA is supporting safe houses in Sindhuli, Udaypur, Argakhanchi, Rolpa, Rukum, Dadeldhura, Accham, Bajhang, Baitadi, Bajura and Kapilvastu. Additionally, the DWC is supporting safe houses in Saptari, Sunsari, Sarlahi, Rautahat, Pyuthan and Dang.

<sup>161</sup> Latest available data. GoN/NHSSP and UKAID: INNOVATIVE GOOD PRACTICES IN NEPAL'S HEALTH SECTOR 3. Hospital-based One-Stop Crisis Management Centres, February 2016.

<sup>162</sup> Outcome 2-training compiled by UNFPA, November 2016. Pyuthan and Rautahat OCMCs were only recently opened. Figures for Saptari and Rautahat also include GBV cases catered for by the district hospital.

<sup>163</sup> Outcome 2-training compiled by UNFPA, November 2016.

always aware about the types of services provided by UNFPA-supported OCMCs and safe houses. Consequently, they arrived late or were hesitant to seek for help.

In addition to its capacity-building support for OCMCs and safe houses, and in order to strengthen referrals, UNFPA has trained other service providers to address GBV - e.g., training for community psycho-social workers and police personnel on GBV. GBV survivors seemed to resort primarily to WCOs for advice and help, from where they have been connected to a safe house or an OCMC. Safe homes, NGOs, the police, psycho-social counsellors and FCHVs have likewise have referred survivors to OCMCs.

The evaluation team was unable to interview GBV survivors to evaluate their responses regarding UNFPA-supported GBV services.<sup>164</sup> However, mothers' groups and women cooperative members expressed their satisfaction with the system in place and the services provided. It was argued that GBV survivors maintain privacy and often are unwilling to openly seek for care, but that this has changed in recent years and more survivors are coming forth to seek for care as knowledge of availability of GBV services has increased.

**IND4.1.6 The extent to which GBV Elimination and Gender Empowerment District Coordination Committees are really functional is questionable.** GBV Elimination and Gender Empowerment District Coordination Committees (GBVEGEDCC) exist in all districts for an improved multi-sectoral response to the needs of GBV survivors and improved referral among various agencies. According to their ToR, GBVEGEDCCs are responsible for developing strategic plans to address GBV; they also allocate resources (provided by the DDC) to implement local-level awareness raising activities, to support GBV survivors, and to hold coordination meetings. Under its regular programme, CP7 committed UNFPA to increasing the functionality<sup>165</sup> of the GBVEGEDCCs in its 18 priority districts.<sup>166</sup> Latest monitoring data reveal that GBVEGEDCCs are functional in all districts.<sup>167</sup>

UNFPA has supported the strengthening of GBVEGEDCCs. However, contradictory to UNFPA monitoring data, responses regarding their performance varied in the districts visited by the evaluation team. In Dang, Baitadi and Sunsari, it was reported that the GBVEGEDCCs met on a quarterly basis, but that they were not very effective. In Sindhuli, the GBVEGEDCC was reported to have been active and effective; it apparently met several times in response to the earthquake. Weaknesses, with which GBVEGEDCCs are confronted, are fluctuating members, lack of a clear agenda and dependence on the leadership of the CDO who is the chairperson.

**IND4.1.7 UNFPA resumed its support for improved GBV data management. Data collected through the GBV Information Management System, while not comprehensive or representative, are expected to be a powerful tool for advocacy and lobbying.** Supported at global level by a Steering Committee comprising of UNFPA, the International Rescue Committee, UNHCR, UNICEF and the International Medical Corps, the Gender-Based Violence Information Management System (GBVIMS) was first rolled out in Nepal in September 2011.<sup>168</sup> CP7 intended to use GBVIMS data as a means of verification, but did not explicitly envisage support for improving it. However, continued lack of data for future GBV interventions was repeatedly pointed out in various forums. The GBVIMS was therefore re-launched in November

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<sup>164</sup> GBV survivors were not present at visited OCMCs and safe houses; it was difficult to organize FGDs with former clients for reasons of privacy, but also distances and heavy workloads of beneficiaries.

<sup>165</sup> "Functional" means holding regular meetings, documenting meeting outcomes and carrying out planned activities.

<sup>166</sup> CPAP 2013-17 Outcome 2 Output 1 Indicator 2. This indicator and target were added to align with UNFPA 2014-17 SP Outcome 2 Output 10 "Increased capacity to prevent gender-based violence and harmful practices and enable delivery of multi-sectoral services, including in humanitarian settings".

<sup>167</sup> Outcome 2-training compiled by UNFPA, November 2016. UNFPA August 2016 monitoring data confirm this information for 16 of the 18 priority districts.

<sup>168</sup> <http://www.gbvim.com/>. <http://nepal.unfpa.org/news/towards-data-uniformity-gbv-gbvims-nepal>.

2014 by eight NGOs<sup>169</sup>, the NWC and UNFPA. The initiative, which two other NGOs joined in 2015, is led and coordinated by the National Women's Commission (NWC) and supported financially and technically by UNFPA. Since 2015, CVICT has been providing technical assistance, including training, to the NWC to collect, analyse and disseminate GBV data. UNFPA has supported the participating NGOs to record GBV survivors and report monthly to the NWC following a standard format. Interviewed stakeholders generally considered UNFPA's support worthy. Data were published in 2016<sup>170</sup> and should serve as a powerful advocacy and lobbying tool. However, one key informant, while welcoming the GBVIMS, spoke out for a single consolidated, government-owned GBV dataset representing the entire country.

**IND4.1.8 GBV services through existing OCMCs appear sustainable, even without further external funding. The same cannot be said of safe houses. Availability of qualified human resources for responding to GBV could become an issue.** UNFPA's assistance has developed the individual capacities of psycho-social counsellors and institutional capacities of safe houses and OCMCs, all of which cater to different needs of GBV survivors and those at risk of violence. UNFPA has worked within existing structures of the GoN; it has not created parallel structures. This bodes well for ownership and policy support.

Interviews conducted by the evaluation team regarding financial sustainability reveal the following: OCMCs are stipulated in the Red Book and UNFPA's additional support is highly appreciated. Interviewed health professionals in Dang and Sunsari were confident that "their" OCMCs have the capacity and the means and resources to operate well even if external support were to continue. However, refresher trainings and capacity building of new staff are required for OCMCs to continue their work. Availability of qualified human resources could also become an issue in the area of community-based psycho-social counselling: there is no guarantee that psycho-social counsellors trained on GBV will continue working since they are in high demand. New counsellors will therefore need to be trained on a continual basis. However domestic funding for refresher courses and training new counsellors is lacking.

In the districts visited by the evaluation team, safe houses, as opposed to OCMCs, are clearly unsustainable without continued external support, although they are also stipulated in the Red Book. Safe houses existed in all districts visited by the evaluation team. However, domestic funding on the part of the WCOs for running the safe houses on a day-to-day basis is inadequate.

#### A.4.2 Prevention of GBV and child marriage

**IND4.2.1 UNFPA has strengthened different networks to mobilize communities against GBV and child marriage.** In its priority districts, UNFPA has capacitated different types of community mobilizers to prevent GBV, support GBV survivors and prevent child marriages and other harmful practises through district-level trainings and orientations. They range from religious leaders, LGCDP social mobilizers, members of girls' circles, women cooperative members and members of women's groups. No assessments or perception surveys are available to document the satisfaction of such community mobilizers supported by UNFPA with trainings and sensitization workshops. Hence it is difficult to gauge opinions. Interviews and discussions provided a broad sense of feedback and views, and overall suggest strong appreciation and satisfaction, as well as a felt vital need for continuation and expansion to more VDCs. For instance, priests and Jyotishis (astrologers) in Baitadi were satisfied with the sensitization training they had attended; they and other stakeholders felt that their involvement in preventing child marriage and chhaupadi was a good strategy. Members of girls' circles/groups in Baitadi and Sunsari were appreciative of Rupantaran training. They stated that their awareness and knowledge on GBV and child marriage had increased, that they had benefited personally, and that they were able to share information in their families and communities and

<sup>169</sup> The eight signatories to the GBVIMS are: Women Rehabilitation Centre (WOREC), Centre for Victims of Torture Nepal (CVICT), Women Forum for Women in Nepal (WOFWON), Nepal Disabled Women Association (NDWA), Action Works Nepal, SAATHI, AWAAZ and Transcultural Psychosocial Organization Nepal (TPO).

<sup>170</sup> <http://www.cvict.org.np/index.php?page=publications>.

had successfully stopped child marriages. Interviewed women cooperative members and social mobilizers were also satisfied with orientations on GE and GBV they had attended.



**WCO and Women Cooperative Beneficiaries in Baitadi District (with Evaluator)**

**IND4.2.2&4.2.5 UNFPA outreach has had an immediate effect on the attitudes of targeted men and boys towards VAW; however, it is doubtful that UNFPA has influenced male attitudes and consequently behaviours on a larger scale.** CP7 committed UNFPA to increasing the percentage of men and boys in its priority districts who believe that violence against women (VAW) is not acceptable.<sup>171</sup> A perception survey conducted by UNFPA in 2013 showed that

only 32.6% of men and boys in its priority districts agreed – i.e., that two-thirds thought violence was acceptable.<sup>172</sup> This attitude is reinforced by women’s perceptions: 2014 MICS data showed that the percentage of women who think that a husband/partner is justified in hitting or beating his wife/partner under certain circumstances was 42.9%. Thus, in the course of the re-alignment exercise, UNFPA also committed itself to reducing the percentage of women aged 15-24 and 15-49 who think that a husband/partner is justified in hitting or beating his wife/partner to zero.<sup>173</sup>

To prevent GBV and to create an enabling environment for survivors to seek support, UNFPA and its partners directly reached out to thousands of men and boys in their communities. It organized orientations for male members of Ward Citizen Forums (WCFs).<sup>174</sup> In some districts, including thanks to UNFPA’s outreach, ward-level action plans to reduce violence were developed. UNFPA also trained selected men and boys to become “champions” committed to breaking the silence on GBV. In 2015, it launched the pilot Men’s Initiative for Lifelong Action and Partnership (MILAP) in four<sup>175</sup> of its priority districts to engage men, boys and women in monthly discussions about GBV.

Information on whether less men and boys in UNFPA-supported districts believe that VAW is acceptable was not available at the time of the evaluation, pending a planned end-line perception survey. Some indication of a change in attitudes thanks to UNFPA can be gauged from 2015 pre- and post-training data: 70% of 3,339 participants secured the 80% passing score. Interviews and discussions conducted by the evaluation team gave the sense that men and boys who had benefited from UNFPA’s outreach activities were indeed more sensitive, but that more efforts are required to cover more and remote VDCs and to bring about actual behavioural change.

**IND4.2.3 In continuation of its earlier work to support adolescent girls to choose their own futures, UNFPA has successfully used “Rupantaran” to empower adolescent girls to speak out to their peers and elders against violence and child marriage. Rupantaran has had a cascading effect on communities, thus benefiting a wider circle of girls.** In 2013, UNFPA supported WCOs in UNFPA-supported districts to empower adolescent girls. More than 500 girls – graduates of the Kishori Bikash Karyakram programme – were orientated on GBV and harmful practises including child marriage. They went on to form adolescent girls’ circles in their villages. In the meantime, 44 girls’ circles have been formed in UNFPA priority districts.

<sup>171</sup> CPAP 2013-17 Outcome 2 Output 2 Indicator 2.

<sup>172</sup> Annual Review Meeting 2015; UNFPA August 2016 monitoring data.

<sup>173</sup> CPAP 2013-17 Outcome 2 Indicator 3. Added as part of re-alignment exercise.

<sup>174</sup> There is one Ward Citizen Forum in every ward of every VDC and municipality, established by the LGCDP. WCFs have 24 members represented by various groups of local communities who sit regularly to discuss their needs and priorities and send them to VDC Council Meetings.

<sup>175</sup> In two VDCs each in Pyuthan, Achham, Dang and Sindhui districts.

In 2014, UNFPA supported the testing and contributed to rolling out the newly-developed SFSP (“Rupantaran”). The initiative was piloted by UNFPA through the WCO in Dang and later rolled out to Baitadi, Bajhang, Accham, Kapilvastu and Rolpa; it was implemented through the National Muslim Women Welfare Society and Madrasa teachers in Rautahat, Kapilvastu and Sarlahi. Given the initiative’s early days, no formal assessment of Rupantaran has been



**Rupantaran Beneficiaries in Baitadi District  
(with Evaluators)**

conducted. Interviews generated positive feedback: GBV stakeholders in Kathmandu as well as officials and beneficiaries in Baitadi and Dang confirmed that the package has increased the knowledge and enhanced the capacities of girls’ circles to address SRH issues such as GBV, HIV, child marriage and menstrual hygiene in their families and communities. UNFPA also directly targeted women and girls through other means and channels with the intention to inform them about GBV and child marriage, to change behaviours and generate demand for services:

- IEC/BCC materials
- Media campaigns and FM radio jingles and mini-dramas
- Orientations for mothers’ groups
- Intergenerational dialogues
- Street dramas

Messages were disseminated through wall paintings, posters, postcards, stickers regarding GBV, child marriage and other harmful practices. The evaluation team saw only few of these in the OCMCs, WCOs and safe houses. Government offices, NGOs, women cooperative members, girls’ circles, and religious leaders distributed these products. However, revising and localizing the content of the messages and production of messages in local languages was felt necessary.

**IND4.2.4 Women survivors of violence generally first seek the advice of Women and Children Offices.** UNFPA expects to increase the proportion of women and girls aged 15-24 in its 18 priority districts who know when and where to seek health services following sexual violence from a very low 11.7% in 2013 to 60% in 2017.<sup>176</sup> A combination of activities under the GE and SRH programmes should help achieve this outcome: activities that immediately target women and adolescent girls such as Rupantaran, CSE and IEC/BCC activities, but also those intended to build supply-side capacities, such as clinical training on GBV for health service providers and the certification of AFHS centres.

For lack of up-to-date statistics, the evaluation team was unable to assess progress. An end-line perception survey is planned for 2017. Evaluation team investigations revealed that women and adolescent girls benefitting from CP7 in whichever way generally knew their options for seeking care. Before taking any course of action, many beneficiaries would generally first seek the advice from WCOs. This is also according to the law and processes stipulated by the state.<sup>177</sup> Of 3,202 women and adolescent girls across all priority districts who were specifically oriented by UNFPA on the health response to GBV in 2015, 80% secured the 80% passing score.

**IND4.2.6&4.2.7&4.2.8 UNFPA has been prominently involved in preventing child marriage through local-level mechanisms; less so to reduce other discriminatory and harmful practises. Already in 2013, a very high 93.3% of surveyed parents did not want their daughters to marry early. This upward trend is expected to continue, including thanks to**

<sup>176</sup> CPAP 2013-17 Outcome 2 Output 2 Indicator 1.

<sup>177</sup> <http://nepal.unfpa.org/sites/asiapacific/files/pub-pdf/TrackingCasesofGBV.pdf>.

**UNFPA’s involvement on the ground. Despite all efforts to educate communities and generally favourable parental attitudes, child marriage is still a challenge, although seemingly a less and less common phenomenon.** In UNFPA priority districts, CP7 intends to increase awareness of child marriage as a harmful practise<sup>178</sup> as a contribution to reducing child marriages.<sup>179</sup> For this purpose, the CO has been supporting existing and creating new community-based mechanisms to engage the population in preventing child marriage and other discriminatory and harmful practises such as chhaupadi, dowry, witch hunting and son preference.<sup>180</sup> A total of 137 such community-based mechanisms were reported to have existed at district and community levels in 17 UNFPA-supported districts (except for Rukum<sup>181</sup>) in 2015, an average of eight mechanisms per district. At the beginning of CP7, child marriage prevention mechanisms had only existed only in two districts, Kapilvastu and Mahottari.<sup>182</sup> UNFPA has supported several different types of community-based mechanisms to address child marriage and other harmful practises. They include existing mechanisms such as WCFs, Citizens’ Awareness Centres (CACs), mothers’ groups, girls’ circles, religious leaders, GBV Watch Groups and inter-generational dialogue, as well as newly-created ones such as GBV-free VDCs and child-marriage free VDCs.

UNFPA expects to contribute to an increase in the proportion of parents in its priority districts who do not want their daughters to marry early.<sup>183</sup> Already in 2013, the perception survey conducted by UNFPA revealed that 93.3% of parents did not want their daughter to be married before the age of 18, which was then the legal minimum age of marriage. Pending the end-line perception survey in 2017, no data are available on the present situation. Even if it were, the extent to which it



**Religious Leaders Beneficiaries in Baitadi District  
(with Evaluator)**

would be comparable is questionable given the increase in the legal age for marriage from 18 to 20. The evaluation team was therefore unable to use the RRF to assess progress and UNFPA’s contribution. In all four visited districts, the evaluation team was informed that more parents have knowledge on the legal age of marriage and that fewer youth were being married early, and that this is now the trend. Team members were given to understand that UNFPA-supported local-level mechanisms were influencing parents’ attitudes towards child marriage. While not representing the overall districts’ knowledge scenario, the evaluation team noted that interventions for orienting 15,119 parents on ending child marriage were successful: of the total number of participants, 80% secured the 80% passing score post-test.

UNFPA has prominently engaged in fighting child marriage at the central and district levels – at the legal/policy level and through its support on the ground. UNFPA interventions were meant to contribute to attitudinal and behaviour change among policy makers and within communities, consequently contributing to a reduction in child marriages, especially in UNFPA’s 18 priority districts.<sup>184</sup> According to the 2011 DHS, the national figure for women aged 20 to 24 who were married or in union before turning 18 was a high 51%. Three years later, the MICS revealed a considerable decrease to 36.6%, which is, however, still one of the highest in the

<sup>178</sup> CPAP 2013-17 Outcome 2 Output 3 Indicator 2.

<sup>179</sup> CPAP 2013-17 Outcome 2 Indicator 2.

<sup>180</sup> CPAP 2013-17 Outcome 2 Output 3 Indicator 1.

<sup>181</sup> By the time of writing, mechanisms were also in place in Rukum.

<sup>182</sup> UNFPA August 2016 monitoring data.

<sup>183</sup> CPAP 2013-17 Outcome 2 Indicator 2.

<sup>184</sup> CPAP 2013-17 Outcome 2 Indicator 2.

world.<sup>185</sup> No updated data are available that would permit a better understanding of trends throughout the period of investigation 2013-16. Based on a re-analysis of 2011 DHS data by the CO, the percentage of women aged 20-24 who were married or in union before age 18 in UNFPA's priority districts was 48.7%, slightly below the national average. The RRF does not provide a 2017 target value for UNFPA districts, and no monitoring data are available.<sup>186</sup>

**IND4.2.9 Efforts to prevent GBV and child marriage largely depend on external financial support, including from UNFPA.** The different interventions referred to above to empower women and girls – e.g., Rupantaran - and to engage communities, directly or through community mobilizers, have been heavily dependent upon external expertise and financial support for DDCs and district line agencies. Sustainability of behaviour change communication and demand generation greatly depends on the extent to which districts are open to allocating their own funds. As to be seen below (IND5.2.6), the percentage of district-level budget allocations for population, SRH, youth and GBV/women's empowerment has considerably increased since 2012, also thanks to UNFPA. However, the evaluation team was unable to do any in-depth analysis to determine whether this has benefitted information, education and communication for preventing GBV and child marriage.

At the national level, political willingness to sensitize the population on GBV and child marriage is there. As seen above (IND3.3.5), UNFPA and NHEICC have agreed, for the first time, upon a costed BCC Strategy and Implementation Plan, which, *inter alia*, covers GBV and child marriage. Funding up until the end of 2017 for activities included in the Plan is secured.

**EQ5 Data, Policies & Planning: To what extent has UNFPA sustainably contributed to a stronger emphasis of national and sub-national policies, plans and budgets on population, SRH, youth and GBV issues in an evidence-based and participatory manner, informed by population dynamics?**

#### **A.5.1 Data availability and analyses on population, SRH, youth and GBV**

**IND5.1.1 UNFPA enabled the Central Bureau of Statistics and the Ministry of Health to conduct and publish national-level surveys and analyses on youth, ageing, migration and urbanization. It provided inputs into the 2014 Multiple Indicator Cluster Survey design.** UNFPA intended to increase the number of national household surveys and census that collected, analysed and estimated data for key population and RH indicators.<sup>187</sup> The baseline was identified as four – i.e., the 2011 Nepal Adolescent and Youth Survey, the 2011 DHS, the 2011 Population and Housing Census, and the NLSS 2011. Latest UNFPA monitoring data<sup>188</sup> indicate that only one additional survey has provided data and analysis for key population and RH indicators, including with UNFPA support – i.e., the 2014 MICS where UNFPA inputted into questionnaire and sample design. The target of seven surveys has not been achieved. The two other anticipated surveys were conducted<sup>189</sup>, but do not address key population and RH indicators.

However, UNFPA has provided technical expertise and funding for CBS and the Population Division of the MoH to conduct other surveys and analyses of national-level data, including further analysis of the 2011 DHS, and notably on youth, ageing, migration and urbanization (Box 3).<sup>190</sup> Interviewed stakeholders were very appreciative of UNFPA's support. At the time of this

<sup>185</sup> <http://www.girlsnotbrides.org/child-marriage/nepal/>.

<sup>186</sup> UNFPA August 2016 monitoring data.

<sup>187</sup> Outcome 3 Indicator 2 was added as part of the re-alignment with the UNFPA 2014-17 Strategic Plan.

<sup>188</sup> Outcome 3: Round IV Data Collection Study, 2016.

<sup>189</sup> These are the Nepal Household Survey 2012 and the National Accounts of Nepal 2012-13.

<sup>190</sup> UNFPA support for the Post-Disaster Needs Assessment in 2015 is discussed under A.6.2.

evaluation, the UNFPA CO was participating in the 2016 DHS Technical Working Group and Technical Advisory Committee.

### Box 3: UNFPA Support for CBS and MoH Surveys and Analyses 2013-16

- In 2013 UNFPA supported the MoH to further analyse 2011 DHS data.
- In 2013 UNFPA provided technical support to the Population Division of the MoH to identify five thematic areas for further analysis of the 2011 Nepal Adolescent and Youth Survey through a series of consultations with key data users and researchers.
- Other studies receiving UNFPA technical and financial support include the National Ageing Survey and the National Migration Survey.
- In 2015 UNFPA initiated and provided full financial support to CBS for conducting an Urban Population Survey. It supported survey design and tools. As of July 2016, field work for data collection was complete. The draft statistical report and draft analysis of demographic indicators based on this survey will be available by the end of 2016.

Sources: UNFPA, CBS

**IND5.1.1 UNFPA technical and financial support facilitated further dissemination of 2011 census results through three Population Monographs.** Already under CP6, UNFPA had made available technical and financial support for conducting the Nepal Population and Housing Census 2011 and for publishing the national report Volume I and other subsequent volumes.<sup>191</sup> UNFPA assistance in piloting the census, field work, post enumeration survey and data analysis was considered important for data quality assurance and improved and sustained data availability and analysis in Nepal. Towards the end of 2013, CBS, with UNFPA support, published additional volumes of census results. They included disaggregated information on households, fertility, migration, industry, occupation, education/literacy and gender amongst other things. UNFPA also provided support for disseminating census results across UNFPA programme districts.

During CP7, UNFPA was able to fully fund the preparation, implementation, printing and dissemination of Population Monograph volumes I, II and III by the CBS in 2014. The three volumes can be accessed online.<sup>192</sup> *Volume I* analyses aspects of population dynamics such as Nepal's population size; growth; distribution and structure; age and sex composition; marriage and fertility; as well as mortality, including maternal mortality and migration. Specifically, as member of a technical committee, UNFPA provided technical support to CBS and the Population Division of the MoH to work on national and sub-national population projections based on the census results, which resulted in the inclusion of population projections for the period 2011-31. UNFPA also enabled the mission of a senior M&E advisor to help CBS undertake an estimation of the maternal mortality ratio (MMR), resulting in the inclusion of a chapter on maternal mortality. UNFPA provided the same kind of technical and financial support for *Volumes II and III* of the Population Monograph. So far there has been no formal attempt to look at the usefulness and the quality of the information included in the three monograph volumes. However, the observed wide use of the information contained in these volumes by researchers, academia and planners/policy makers asserts the quality and usefulness of these publications.

**IND5.1.2&5.1.3 Progress in setting up new databases has been modest. In addition to the CD ROM-based NepalInfo, the web-based CensusInfo is a new important database for experts and other interested persons to access and analyse census-related data, but it is not well known. Other anticipated databases are still under development.** CP7 envisages an increase in the number of databases with population-based data accessible by users through web-based platforms.<sup>193</sup> The target was to create/strengthen four new databases: CensusInfo,

<sup>191</sup> CBS 2012: National Population and Housing Census 2011, Vol. 1, National Report, p10. See

<http://unstats.un.org/unsd/demographic/sources/census/wphc/Nepal/Nepal-Census-2011-Vol1.pdf>.

<sup>192</sup> See [http://cbs.gov.np/sectoral\\_statistics/population/populationmonographnepa\\_2014](http://cbs.gov.np/sectoral_statistics/population/populationmonographnepa_2014). In English.

<sup>193</sup> CPAP 2013-17 Outcome 3 Output 2 Indicator 2.

District Health Information System (DHIS), Population Management Information System (PMIS) and the District Planning, Monitoring and Analysis System (DPMAS)<sup>194</sup>. As of now, progress has been modest. Only one is functional, but not well known.

UNFPA continued to support the publication of NepalInfo on CD-ROM to facilitate a wider dissemination of disaggregated census data by reaching those who do not have access to the internet.<sup>195</sup> The latest release of this database is NepalInfo 2014. It is considered a user-friendly database that can easily produce a wide variety of data tables, graphs and maps. The CD-ROM contains data for different time periods that are disaggregated by sex and administrative and geographic areas wherever data are available. With UNFPA support a total of 150 persons from the districts were trained on NepalInfo.

In 2013, UNFPA supported a week-long master training of trainers for eight CBS officials on the CensusInfo database tool. In 2014, and with UNFPA support, CBS launched the CensusInfo database software package for disseminating 2001 and 2011 census results on CD-ROM and on the web.<sup>196</sup> The user's perspective on this database has not been formally assessed, but key interviewees considered it user-friendly and confirmed that it easily produces a wide variety of data tables, graphs and maps. As of August 2016, 270 local users/planners had been trained on its use. However, most interviewees at central and district level were unaware of this new database. They had not used it and were unable to talk about its usefulness.

Furthermore, the development of the DHIS was in its final stages with technical and financial assistance from UNFPA, WHO and the University of Oslo, accommodating Nepali features. At the time of the evaluation, preparations for its establishment were nearly complete: the software/database was ready and the GoN was planning its launch.<sup>197</sup> Not much progress has been reported on the establishment or the functionalization of the PMIS.

**IND5.1.4 UNFPA has not helped more ministerial statistics units to produce evidence-based analyses on A&Y, SRH, GBV, GE and social inclusion beyond the Central Bureau of Statistics and the Ministry of Health.** As part of the re-alignment exercise, UNFPA committed to increasing the number of national statistical authorities that have the capacities to analyse and use disaggregated data on A&Y, SRH, GBV, GE and social inclusion – up from two (CBS and the MoH) to seven – i.e., CBS, MoH, MoFALD, MoWCSW, MoYS, MoPE and the Ministry of Science and Technology.<sup>198</sup> Latest UNFPA monitoring data reveal no progress. However, while UNFPA has not expanded its support to other ministries, it has continued to build the capacities of CBS and the MoH to analyse and use disaggregated data on A&Y, SRH, GBV, GE and social inclusion. A number of publications and reports by MoH and CBS, including the Population Monographs, are evidence of this support.

**IND5.1.5 Especially CBS is in a better position to sustain its operations, but it still requires external financial and technical support. Upcoming administrative reforms at sub-national level will necessitate stronger data gathering, analysis and management in the public sector.** In Nepal, the need for data collection and analysis has been increasing and widening in recent years; it will continue to do so, including because of new databases that need to be fed and because of the expected decentralized administrative reforms. Despite enhanced capacities, CBS continues to require financial and technical support for further census analyses and for sustaining the census database system. CBS, and other statistic units, also depend on continued support from external sources, including UNFPA, for other activities such as conducting surveys, data analysis, report preparation and dissemination, capacity building/training, logistics support and technical inputs.

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<sup>194</sup> DPMAS is discussed in detail below: Planning and reporting at district level.

<sup>195</sup> Outcome 3: Round IV Data Collection Study, 2016.

<sup>196</sup> Available at: <http://dataforall.org/dashboard/nepalcensus/>.

<sup>197</sup> Outcome 3: Round IV Data Collection Study, 2016.

<sup>198</sup> Outcome 3: Round IV Data Collection Study, 2016. CPAP Outcome 3 Output 2 Indicator 3.

## A.5.2 Policy making and planning at national level

**IND5.2.1 UNFPA-supported data analysis, capacity-building initiatives and advocacy efforts have influenced major policy documents, strategy papers and plans, including at the highest level. The new Constitution and the 2015 National Population Policy are two such highlights. Working with the legislative has leveraged UNFPA's positioning.** Since the beginning of CP7, UNFPA has been contributing to policy and plan formulation processes at the national level. As previously seen (A.5.1), UNFPA has contributed to data generation and analyses on population, SRH, youth and GBV for national policy making and planning. Since 2013 the CO has also, on numerous occasions, built the capacities of national authorities to better integrate UNFPA's mandate in Nepali policies and plans, including through CDPS/TU. Capacity building continued in 2016. Key recipients of such support were the Population Division of the MoH, NPC and MoFALD. Capacity building activities included: provision of technical expertise – e.g., recruitment of a senior demographer to facilitate the new National Population Policy formulation process at MoH; study tours and participation in international conferences - e.g., a study tour was arranged for Population Division's officials to the Philippines; facilitation of inter-sectoral consultations – e.g., support for the NPC during the pre-consultation phase for developing the 13th Plan; orientations and trainings; and organization of conferences in Nepal – e.g., support for MoH and CDPS/TU to organize the first National Population Conference in Kathmandu in 2014.<sup>199</sup>

UNFPA also targeted stakeholders outside the bureaucracy. For instance, in 2014, UNFPA trained 84 national journalists to better cover population issues. In 2014-15, it provided financial and technical support for establishing and operationalizing the National Forum of Parliamentarians on Population and Development (NFPPD), which, in partnership with UNFPA, has successfully advocated for population issues within and outside the parliament.<sup>200</sup>

The re-aligned RRF commits UNFPA to increasing the percentage of new national development plans that address PD by accounting for population trends and projections in setting development targets.<sup>201</sup> At the outset of CP7, four national development plans addressed PD. According to latest UNFPA monitoring data, the target of seven has already been surpassed: an additional six new national development plans have been adopted by the GoN, with UNFPA contribution.<sup>202</sup> They are the Population Perspective Plan 2010-2031, the 13<sup>th</sup> Plan 2013/14-2015/16, the National Health Plan 2014 and the Nepal Health Sector Strategy 2015-20<sup>203</sup>, the National Population Policy 2015, and the 2015 Constitution of Nepal.<sup>204</sup> In particular, UNFPA and its partners contributed to the formulation and endorsement by the GoN of a rights-based and inclusive National Population Policy in 2015. The design and formulation of the Population Policy was based on the UNFPA-supported National Population Perspective Plan 2010-31. Moreover, advocacy with national parliamentarians led to the inclusion of safe motherhood and RH as a fundamental women's right and of the term population "management" in the new Constitution of Nepal. This was the first time in the history of constitution making in Nepal that these issues were recognized as fundamental rights. Based on document analysis and interviews, the evaluation team would like to add others. In line with the RRF, UNFPA support is also reflected in other major policy and plans (Annex 8), including the 14<sup>th</sup> Plan Approach Paper

<sup>199</sup> <http://nepal.unfpa.org/publications/first-national-population-conference-2014-post-conference-proceedings>.

<sup>200</sup> NFPPD has created four sub-committees: Local Development and Accountable Governance, Gender Equality and Women Empowerment, Children and Youth Concern, and Senior Citizen Welfare Concern. Source: NFPPD Introductory Booklet.

<sup>201</sup> CPAP 2013-17 Outcome 3 Indicator 3. The following analysis is limited to the work under the PD component. Similar work under the other CP7 outcome areas is reflected elsewhere in the report.

<sup>202</sup> One pre-dates CP7.

<sup>203</sup> This report talks to these health-focused national policy documents under EQ3.

<sup>204</sup> Source: UNFPA Outcome 3: Round IV Data Collection Study, 2016.

2016/17-2018/19, the 2015 National Youth Policy and the Youth Vision 2025 and 10-Year Strategic Plan 2015.

**IND5.2.2&5.2.3 Eight national-level government agencies are implementing programmes that respond to population, SRH, youth and/or GE, against five at the beginning of CP7. However, not all were influenced by UNFPA; this is only around a quarter of all existing agencies; and UNFPA is not likely to reach its target. At the same time, despite UNFPA's efforts, the percentage of the national budget allocated for population, SRH, youth and GE declined considerably from 10.5% in FY 2012-13 to 3.1% in FY 2015-16 instead of increasing to the targeted 15%.** In FY 2015-16, the Nepali central governance system consisted of 30 ministries and one line agency (CBS under the NPC).<sup>205</sup> Of those, eight had implemented part of their annual work plans and budgets responding to population, SRH, youth and GBV issues – up from five in 2012-13 (Table 11). The CP7 target for end 2017 is 15.<sup>206</sup> It can be assumed that UNFPA first and foremost influenced six of its close government partners as the evaluation team did not come across evidence of influence on the other two. The agencies reportedly implementing programmes on population, SRH, youth and/or GBV/women's empowerment in FY 2015-16 were first and foremost UNFPA close government partners – i.e., MoH, MoWCSW, CBS, MoPE, MoYS, and MoFALD. UNFPA programmatic support for these agencies mainly focused on policy development, coordination, capacity building, youth participation and development, and data and research. The other two are the Ministry of Land Reform and Management and the Ministry of Information and Communication.<sup>207</sup>

UNFPA intends to influence the percentage of national budget allocated for population, RH, youth and GBV issues.<sup>208</sup> Available data indicate that in the baseline period prior to CP7 implementation, 10.5% of the national budget (NPR35.6m) was allocated. In 2016, allocations decreased to 3.1% (NPR38.1m) (Table 11). No breakdown is available for the different issues.<sup>209</sup> No plausible explanation exists for the decline in the third year of CP7 implementation (FY 2014-15). There are two main reasons for the further reduction in budget allocations in FY 2015-16. First, due to the massive earthquake in April 2015, planned budgets were reallocated to emergency-related programmes. Second, the reorganization of some of the ministry and national line agencies later on in 2015 resulted in the restructuring of programmes and budgets.

**Table 11: # of Ministries/Line Agencies Implementing Programmes on Population, SRH, Youth and GBV and % of National Budget Allocated**

CP7 Indicators	Baseline FY 2011/12	Nepali Fiscal Year				CP7 Target 2017
		FY 2012/13	FY 2013/14	FY 2014/15	FY 2015/16	
Total # of ministries/line agencies working at the national level	27	27	27	27	31	-
# of ministries/line agencies implementing programmes on population, SRH, youth and GBV at national level, with UNFPA contribution	5	5	7	7	8	15

<sup>205</sup> In FY 2015-16 the GoN initiated a ministerial restructuring process. As a result, the total number of national-level ministries and line agencies increased from 27 at the beginning of CP7 to 31.

<sup>206</sup> CPAP Outcome 3 Output 1 Indicator 1: # of key sectoral ministries that have implemented their annual work plans and budgets responding to population, ASRH, youth and GBV issues, including in emergencies. Sources: UNFPA Outcome 3: Round IV Data Collection Study, 2016; August 2016 monitoring data.

<sup>207</sup> Sources: Outcome 3: Round IV Data Collection Study, 2016.

<sup>208</sup> CPAP 2013-17 Outcome 3 Indicator 1.

<sup>209</sup> UNFPA Outcome 3: Round IV Data Collection Study, 2016.

% of national budget allocated for population, RH, youth and GBV, with UNFPA contribution	10.5%	4.5%	9.1%	5.8%	3.1%	15%
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Source: UNFPA: Outcome 3 Round IV Data Collection Study, 2016; August 2016 monitoring data

#### A.5.2 Policy making and planning at district level

**IND5.2.4 The number of districts using UNFPA-supported census and national surveys in their planning processes has increased considerably, but is still rather low. Moreover, use is only partial.** UNFPA expects to increase the number of its priority districts that use data from census and national surveys in their District Development Annual Plans.<sup>210</sup> Latest UNFPA monitoring data shows that only seven of the 18 UNFPA-supported districts had utilized data, and this only for selected key ICPD indicators – i.e., CPR, ANC visits, and total HIV cases.<sup>211</sup> However, the evaluation team noted that this number was up from zero. DDCs also develop five-year Periodic District Development Plans. As of October 2016, 10 districts out of 18 were developing their Periodic Plans. Data from UNFPA-supported census and national surveys have been only partially utilized. Interviews revealed considerable importance given to evidence-based planning. Unavailability of updated and district-disaggregated data was the main reason for non-utilization of data for all key indicators in planning processes.<sup>212</sup>

**IND5.2.6 Contrary to the national level, the percentage of district-level budget allocations for population, SRH, youth and GBV/women’s empowerment has increased considerably across UNFPA’s priority districts, with UNFPA contribution.** In parallel, UNFPA expected an increase in DDC budgets for population, RH, youth and GBV.<sup>213</sup> The evaluation team noted a steady increase - from an aggregated very low 1.7% across UNFPA priority districts in FY 2011-12 to 6.4% in 2016. Combined annual budgets (DDC, DHO, DEO, and WCO) reached 12.8%, up considerably from 3.5% (Table 12). UNFPA financial support and the presence of UNFPA District Programme Officers are assumed to have played a role. While the target for combined budgets is in sight, the target for DDC budgets seems out of reach within the duration of CP7.

**Table 12: % of DDC Budgets for Population, RH, Youth and GBV in UNFPA-supported Districts**

CP7 Indicators	Baseline FY 2011/12	Nepali Fiscal Year				CP7 Target 2017
		FY 2012/13	FY 2013/14	FY 2014/15	FY 2015/16	
% of DDC budgets allocated for population, RH, youth and GBV issues in 18 UNFPA programme support districts <sup>214</sup>	1.7	3.8	4.3	6.2	6.4	18.0
% of district budgets (combined budgets of 4 government line agencies - DDC, DHO, WCO and DEO) allocated for population, RH, youth and GBV issues in 18 UNFPA programme support districts	3.5	5.9	7.0	11.9	12.8	15.0

Source: UNFPA Outcome 3: Table 10, Round IV Data Collection Study, 2016

**IND5.2.5 Authorities in UNFPA priority districts have not reported on ICPD indicators in a comprehensive manner. None have reported based on the District Planning, Monitoring**

<sup>210</sup> CPAP 2013-17 Outcome 3 Output 2 Indicator 1.

<sup>211</sup> UNFPA August 2016 monitoring data; UNFPA Outcome 3 Round IV Data Collection Study 2016.

<sup>212</sup> UNFPA Outcome 3 Round IV Data Collection Study 2016.

<sup>213</sup> CPAP Outcome 3 Indicator 4.

<sup>214</sup> UNFPA Outcome 3: Table 10, Round IV Data Collection Study, 2016, p28.

**and Analysis System, revised and re-introduced with the support of UNFPA and UNICEF.**

During CP6, preparatory works were being carried out to revise the District Planning, Monitoring and Analysis System (DPMAS). In 2013 and 2014, a revision of DPMAS and a number of activities were carried out to revitalize the system. With the support of UNFPA and UNICEF, NPC and MoFALD revised the DPMAS guidelines and software in consultation with other line ministries and based on feedback from the districts. The revision resulted in better harmonization of the guidelines and software with the monitoring indicators and reporting tools of line ministries and district line agencies. UNFPA District Programme Officers organized DPMAS orientations for district officials in most UNFPA priority districts. As a result, the concerned DDCs were able to submit DPMAS first reports to MoFALD. Orientations continued in 2015, but were interrupted by the effects of the earthquake and adverse political situation.

Irrespective of these efforts, DPMAS has not been operationalized in the majority of UNFPA priority districts due to several factors, including frequent changes of DPMAS software and guidelines by MoFALD, lack of ownership by line ministries, lack of follow-up and supervision by MoFALD, frequent transfer of trained staff, and weak logistics. There has been good progress in making DPMAS functional in Sindhuli district. Orientation on new software was conducted in Sindhuli and district-level development-related data for a three-year period entered. It was also reported that district-level joint monitoring of development activities was initiated utilizing DPMAS and that the district was planning to make DPMAS a web-based system in the near future.<sup>215</sup> A special effort has also been made to revitalize DPMAS in Udayapur and Mahottari districts. However, none of the DDCs have so far reported on key ICPD indicators using DPMAS data and information.<sup>216</sup>

Ultimately, an analysis of district annual reports revealed that no UNFPA priority district has reported on all key ICPD indicators.<sup>217</sup> Of the 18 priority districts, five had reported on CPR, seven on ANC visits, six on STI, and seven on HIV cases. Furthermore, three districts had covered other indicators such as women representation in district councils, women representation in public service and GBV cases; one district had reported on the ratio of boys to girls in secondary level education.<sup>218</sup>

**IND5.2.7 The sustainability of important policy and planning processes for advancing the ICPD agenda is affected by political uncertainties.** The development of the 2015 National Population Policy and the 13<sup>th</sup> National Plan were based on the UNFPA-supported long-term Population Perspective Plan 2010-31. The 14<sup>th</sup> Plan Approach Paper (2016/17-2018/19) and other policy/plans were drawn up, with UNFPA contribution, based on the Population Policy and other sectoral policies such as the National Health Plan, the NHSS and the National Youth Policy. In 2015, the GoN initiated the process of developing a National Population Act, which was meant to provide more clarity on various aspects related to population, SRH, youth and GBV. This process, however, has been delayed indefinitely, most probably due to the current political situation and the non-clarity on when and how the state restructuring process will proceed and the timing for the new structure to be put in place.

**A.5.3 Participation of young people and vulnerable women in policy making and planning**

**IND5.3.2 Collaboration with youth-led NGOs and the Ministry of Youth and Sports has facilitated participation of youth in central-level policy making and planning. UNFPA was instrumental in the recent establishment of a National Youth Council and district youth councils.** RRF Outcome 3 Output 3 reads “Strengthened capacity of networks for youth and for vulnerable women at central and local levels to influence development policies, plans and

<sup>215</sup> UNFPA Outcome 3 Round IV Data Collection Study, 2016.

<sup>216</sup> CPAP 2013-17 Outcome 3 Output 2 Indicator 2. Source: UNFPA August 2016 monitoring data.

<sup>217</sup> CPR; ANC visits; SBA use; STI and HIV cases; women representation in district council and public services; total GBV cases; and ratio of girls to boys in secondary level education. Source: UNFPA Outcome 3 Round IV Data Collection Study, 2016.

<sup>218</sup> Source: UNFPA Outcome 3 Round IV Data Collection Study, 2016.

budgets”. UNFPA has supported youth participation at central level. But for lack of an indicator, it has not tracked its contribution. UNFPA has collaborated with the GoN and civil society to increase youth participation in central-level policy making and planning, mainly with the UN Youth Advisory Panel (UNYAP), Restless Development and the MoYS. During CP7, UNFPA provided support on various occasions for UNYAP to be heard and have an influence (Box 4).

#### Box 4: UNFPA Support for UNYAP Influence on National Policies and Plans

- Support for advocating youth issues in other UN agencies
- Consultation with UN agencies on SDG localization process
- Celebration of international days
- Networking with national and international youth networks/groups
- Mapping of youth networks/agencies currently working in Nepal

Sources: UNYAP; UNFPA

The youth-led NGO Restless Development entered into partnership with UNFPA in 2012. With UNFPA support, it contributed to the report “Nepali Youth in Figures” and established a youth database. It introduced the Youth Score Card, which is regarded as an effective mechanism for assessing the UNCT’s programme from a youth perspective and as an effective advocacy tool.<sup>219</sup>

UNFPA has worked with the MoYS since the beginning of CP7. In 2013, UNFPA, along with others, provided technical, financial and material support for elaborating the National Plan of Action for the Holistic Development of Adolescents. It facilitated the consultation of 2,000 adolescents from across the country. In 2013-14, UNFPA supported youth participation in the MoYS-led process to elaborate a National Youth Policy and Implementation Plan as well as the Youth Vision 2025. In October 2016, the National Youth Policy Implementation Plan was finalized. Interviewees agreed that these were good achievements that paved the way for a more focused approach to youth development. In 2014, UNFPA provided support to MoYS for further analysing census data on adolescent and youth population. The report was published in 2014 as “Nepali Youth in Figures”.

In 2015, UNFPA initiated the National Adolescents and Youth MDG Charter, which was launched as part of the post-2015 Agenda and shared with the UN General Assembly by the MoYS. UNFPA, together with UNICEF and Restless Development, had conducted extensive district-level consultations with over 500 A&Y across 41 districts beginning in 2013. The Charter is considered a reference document for drafting policies, development plans and programmes that affect young people’s lives. In 2015, UNFPA was instrumental in supporting the establishment by the MoYS of a National Youth Council in Kathmandu and youth councils in 64 districts of Nepal. Status, functions, funding and working modalities are not yet clear.

Last but not least, UNFPA has enabled a number of governmental and non-governmental stakeholders to participate in international trainings and forums in- and outside the UN such as the Special Session of the Commission on Population and Development on ICPD beyond 2014 in New York, the first Global Forum on Youth Policies in Azerbaijan, the UN ECOSOC Youth Forum on Transition from the MDGs to the SDGs in New York, and the SAARC Regional Dialogue on Promoting Youth Participation in the Implementation of the SDGs.

**IND5.3.1&IND5.3.3 UNFPA has organized youth in its priority districts. Youth are increasingly vocal in district development processes through youth network members. Youth representatives were mainly male and not many were from disadvantaged groups; their age is not known. UNFPA has not worked with vulnerable women in an organized manner similar to youth networks.** Under CP7, UNFPA committed itself to increasing the percentage of youth from district-level youth networks in its priority districts who participate in local government planning processes – more precisely in DDC Council meetings and District

<sup>219</sup> Restless Development. UNCT Nepal, Youth Score Card, 2009:

<https://www.google.com/search?q=What+is+youth+score+card%3F&ie=utf-8&oe=utf-8&client=firefox-b>.

Integrated Planning Committee (DIPC) meetings.<sup>220</sup> Overall, according to UNFPA monitoring data, youth were hardly visible in district-level planning processes at the beginning of CP7. Since that time, youth participation has shown an increasing trend (Table 13), and the target of 20% is likely to be met: in FY 2015-16 youth network members represented 16.3% of all DDC council meeting participants and 21.4% of DIPC participants. Data is available by sex and by disadvantaged groups: they show that youth were less represented by young women than by young men.<sup>221</sup> Youth categorized as belonging to disadvantaged groups<sup>222</sup> were even less present.<sup>223</sup> Data on the age of youth network member representatives is not available.

**Table 13: % of Youth Network Member Participation in District Planning**

CP7 Indicator	Baseline FY 2011/12	Nepali Fiscal Year				CP7 Target 2017
		FY 2012/13	FY 2013/14	FY 2014/15	FY 2015/16	
% of youth network member participation in DDC council meetings	1.4	2.1	5.2	16.7	16.3	20.0
% of youth network member participation in DIPC meetings	1.7	13.1	2.5	17.4	21.4	20.0

Source: UNFPA Outcome 3 Round IV Data Collection Study, 2016

To increase youth participation, UNFPA has not only built the capacities and facilitated the participation of existing youth networks comprising various local-level youth groups. Beginning in 2013, it helped initiate and form new youth networks in its priority districts and at the level of VDCs. As of October 2016, a total of 504 youth networks had been formed with a total membership of 7,519 youth in all UNFPA priority districts.

UNFPA capacity building for youth networks has been implemented by Restless Development. Youth network members have been trained on local-level planning processes, results-based management, monitoring and evaluation, and evidence-based advocacy. Other good examples of youth empowerment were found in the districts visited by the evaluation team. In Dang, UNFPA supported the establishment of “Illaka” level Youth Information Centres.<sup>224</sup> In Sindhuli, youth network representatives are now represented on WCFs. UNFPA-supported youth networks are also being consulted by district stakeholders other than DDCs - for example, youth networks in Dang and Rukum were consulted by local line agencies and development partners when planning and reviewing their programmes.

UNFPA has not worked with vulnerable women in an organized manner similar to youth networks. CP7 Outcome 3 Output 3 reads “Strengthened capacity of networks for youth and for vulnerable women at central and local levels to influence development policies, plans and budgets”. As concerns civic representation of vulnerable women, the RRF contains no performance indicator; therefore, no monitoring data is available. Interviews and document analysis revealed that UNFPA has not implemented a programme to strengthen and create vulnerable women networks similar to youth networks. Through UNFPA’s participation in and support for the LGCDP, its support for youth networks, and its empowerment activities with community (demand-side) institutions such as WCFs and CACs on issues around GBV, SRH and child marriage, it has, however, indirectly contributed to bottom-up representation of women’s interests in local governance. According to the 2016 LGCDP Annual Report, “women’s involvement in local-level affairs ... seem[s] highly encouraging”.

<sup>220</sup> CPAP 2017 Outcome 3 Output 3 Indicator 1.

<sup>221</sup> Young women accounted for 22% of youth network representatives in DDC council meetings and around 19% in DIPC meetings in 2015/16.

<sup>222</sup> Defined as a group of people who are considered either socially and or economically deprived.  
<http://daginfo.deprosc.org.np/StartPage.aspx>.

<sup>223</sup> Youth from disadvantaged groups accounted for 5.2% of youth network representatives in DDC council meetings and around 8.5% in DIPC meetings in 2015/16. There is no breakdown by gender.

<sup>224</sup> “Illaka” is a sub-district level electoral boundary that consists of several VDCs.

**IND5.3.4 Sustainability of UNFPA-supported youth participation is not secured.** UNFPA's primary focus from the beginning of CP7 has been at sub-national level. Youth network members have been capacitated to the extent that they are able to claim participation in district development processes. Youth participation in DDC and DIPC meetings has been formalized with DDC-level decisions. From this point of view, benefits are likely to be sustainable, at least in the short run. However, youth networks are loose forums with no legal basis. Also, key informants noted that working with young people can be challenging: individuals move in and out of the youth age bracket and are mobile. Although youth participation in district development processes currently shows an increasing trend, including thanks to UNFPA, the extent to which representatives of future youth generations will be willing and able to participate is an unknown.

#### **EQ6 Emergency Preparedness and Response: To what extent was (is) UNFPA, along with its partners, likely and able to respond to crises?**

*This evaluation question delves into the effectiveness of UNFPA's emergency preparedness and response. Two assumptions assess this question. The first covers UNFPA's effectiveness in supporting the country to prepare for a disaster or emergency. The second presents UNFPA's contribution to humanitarian action in 14 districts after the massive earthquake in April 2015. Emergency preparedness and response are also discussed under the added value evaluation criterion below (A.9.2).*

#### **A.6.1 UNFPA's contribution to enhanced emergency preparedness in Nepal**

**IND6.1.1 More UNFPA priority districts have incorporated MISP in their Disaster Response Plans, including thanks to UNFPA. To strengthen Nepal's emergency response preparedness, the CO has in some instances even focused on village-level disaster preparedness.** One of the original CP7 targets is to increase the number of UNFPA priority districts with contingency plans that incorporate MISP, GBV and ASRH components.<sup>225</sup> In 2014, the UNFPA CO had reported that District Disaster Relief Committees (DDRCs) lacked commitment and funds to prioritize SRH and protection. Latest CO monitoring data reveal that District Disaster Preparedness and Response Plans (DPRPs) for all 18 UNFPA priority districts are now sensitive to these issues.

Interviews in all four districts confirmed that this was indeed the case. Numerous representatives of concerned district authorities confirmed that UNFPA support, including funding, technical advice and trainings for DDRC members, has contributed to this stronger emphasis on MISP, GBV and ASRH in DPRPs. In Dang, UNFPA is even the assigned District Lead Support Agency in support of the DDRC.<sup>226</sup> Concerned UNFPA staff ascribed this particular status to the presence of the RSO in the district, strong local staff competencies in emergency preparedness and UNFPA's comparative advantage in population dynamics. However, they found it not only an opportunity to strengthen the organization's reputation as a humanitarian agency; it is also an additional burden for staff. A desk review of the latest and updated DPRPs for these districts<sup>227</sup> revealed inclusion of issues related to UNFPA's mandate: districts have incorporated MISP and GBV in their Plans; as well as health and nutrition, protection/emergency shelter and ASRH. Sindhuli has incorporated GBV and health and nutrition. UNFPA is listed as a player in all four.

Disaster response preparedness in Nepal is four-tiered: Besides national, regional and district-level structures, VDCs are also responsible for disaster preparedness and response at local level.<sup>228</sup> Key informant interviews in Baitadi revealed that sub-district awareness and capacities

<sup>225</sup> CP7 Outcome 1, Output 1, Indicator 4.

<sup>226</sup> This is the only district where UNFPA has been appointed as DLSA.

<sup>227</sup> DPRPs of Sindhuli (FY 2013-14); Sunsari (FY 2014-15); Dang (FY 2015/16); Baitadi (FY 2015-16)

<sup>228</sup> NDRF, July 2013.

were “poor”, “lacking”, “low”, a particular problem given the geographical remoteness and difficult accessibility of many VDCs. In Sunsari, health service providers suggested to create more awareness and coping skills among communities and service providers in 19 flood-prone VDCs adjacent to the Koshi River. In places, UNFPA has responded to local-level needs: in Sindhuli, UNFPA-supported orientations/trainings for Local Disaster Management Committees (LDMCs) in disaster-prone VDCs reportedly led to a reactivation of emergency preparedness activities. In Dang, UNFPA helped to establish CDRCs in over half a dozen VDCs; they have started preparing Local Disaster Management Plans.

An external review of the UNFPA Guidance Note on Minimum Preparedness, published in 2015, found that working not only with national authorities but also with local governments to include issues related to UNFPA’s mandate in their contingency plans is a good practice.<sup>229</sup>

**IND6.1.1 Besides support for disaster response *planning* in its priority districts, UNFPA has also contributed to cluster *coordination* in health and protection.** As one key informant said, “only having a plan is not sufficient”. To further strengthen emergency preparedness and response, UNFPA has therefore also participated in the humanitarian cluster approach at district level. In its priority districts, UNFPA is a member of WCO-led protection clusters and DHO-led health clusters. Apart from providing technical advice for developing cluster contingency plans, it has made available funding to regularize cluster meetings. Contrary to its role within the national protection and health clusters, UNFPA has not played a formal lead role at district level. However, this is about to change: the recently endorsed National Protection Cluster Strategic Plan has defined the formal co-lead role of UNFPA in district-level protection clusters where it has a physical presence and the necessary capacities.

**IND6.1.2 UNFPA has contributed to an inclusion of dignity kits in Nepal’s emergency response preparedness strategy; it has been part of joint efforts to scale up prepositioned dignity kits to ensure effective emergency response. Prepositioning of RH kits is also part of UNFPA’s support for emergency preparedness.**

“The prepositioning of RH kits and dignity kits along with strengthening coordination mechanisms, contingency planning and capacity development is part of UNFPA support to the Government of Nepal’s work on emergency preparedness”. *Giulia Vallese, UNFPA Representative Nepal: Reproductive Health Kits and Dignity Kits Are an Important Component of Disaster Preparedness, August 22<sup>nd</sup> 2016*<sup>230</sup>

The importance of prepositioning in Nepal was emphasized by many interviewees. Under CP7, UNFPA started to preposition RH kits, something it had not done under CP6. The April 2015 earthquake, however, seems to have been a big wakeup call, and UNFPA also started prepositioning dignity kits and other emergency relief items. The need for adequate and up-scaled prepositioning of emergency supplies, not just by UNFPA, was underscored in interviews. Very recently, the protection cluster, co-led by UNFPA, agreed upon minimum standards and defined the contents of dignity kits in the 2016 National Protection Cluster Strategic Plan.

Prepositioning is thus a joint undertaking of the GoN and humanitarian organizations. UNFPA has contributed a minimum amount of dignity kits in some, but not all, of its priority districts for the case of small-scale emergencies such as fires and landslides. They are stored at the WCOs. For large-scale emergencies, the CO has also prepositioned a limited amount of dignity and RH kits and other commodities at strategic points in Kathmandu and throughout its geographical clusters – i.e., in UNFPA RSOs and hospitals managed by the NRCS.<sup>231</sup> Funding limitations as well as inadequate storage, logistical and management capacities, including expiry issues, influenced

<sup>229</sup> Guidance Note on Minimum Preparedness Review, Findings and Recommendations, Draft, December 2015, p12.

<sup>230</sup> Press release downloaded from <http://www.unfpa.org/transparency-portal/unfpa-nepal>.

<sup>231</sup> Giulia Vallese: Reproductive health kits and dignity kits are an important component of disaster preparedness, August 22<sup>nd</sup> 2016 (press release downloaded from <http://www.unfpa.org/transparency-portal/unfpa-nepal>).

decisions about where and how many kits to preposition. A prepositioning strategy, including inventory, is prepared on a yearly basis for HQ approval.

According to the corporate UNFPA dignity kit guidelines<sup>232</sup>, prepositioning dignity kits is advisable for countries facing recurring disasters; maintaining a “safety stock” of prepositioned kits in-country has been shown to greatly improve the timeliness of the emergency response. In the four visited districts, the evaluation team observed that WCO offices had varying numbers of dignity kits, funded by UNFPA, at their disposal, except for Baitadi where none were to be found. Various district officials pointed out that more kits were required for effective emergency response preparedness. This seems to generally be the case throughout Nepal. The content of the dignity kits was agreed with the GoN taking into account Nepal’s socio-cultural context: the kits include a sari, petticoat and shawl, or kurta, as well as sanitary pads, other hygiene items and a flashlight for protection purposes. However, stakeholders in Sunsari and Sindhuli reported that some items should have been better customized to local climatic conditions. Safe storage space was also highlighted as a problem as the evaluation team also observed first-hand in Sindhuli where some had been destroyed by vermin. On the pros and cons of investing limited funding in procuring dignity kits, one key informant shared the view that dignity kits are not just supplies, but an important entry point for conversations with vulnerable women and adolescent girls on GBV prevention. They also help strengthen the role of WCOs as first responders in humanitarian situations.

UNFPA HQ maintains a stock of 13 different essential RH kits, designed to respond to three month’s need for various population sizes. The UNFPA Nepal CO has reportedly prepositioned RH kits in Kathmandu and clean delivery kits (Kit 2A) in its RSOs in order to be able to respond rapidly to the needs of affected populations in case of an emergency.

**IND6.1.3 Provision is made for Standard Operating Procedures on GBV in humanitarian settings in the National Protection Cluster Strategic Plan. The SOPs are in the making, funded by UNFPA.** In 2015, UNFPA, in collaboration with the MoWCSW, commissioned NRCS to develop SOPs on GBV in humanitarian settings. At the time of the evaluation, work was still pending or rather postponed because of difficulties identifying a national consultant. Meanwhile, the National Protection Cluster Strategic Plan, which was recently endorsed by the MoWCSW, mentions the provision of GBV SOPs in humanitarian settings.

**IND6.1.4&6.1.5&6.1.6&6.1.7 Officials, service providers, youth and NRCS volunteers were trained on MISP, SRH and GBV in emergency settings. Knowledge has increased thanks to such emergency preparedness trainings. Ministry of Health Rapid Response Teams at the central and district levels are better able to cope with RH issues during emergencies, thanks to UNFPA. The government has endorsed a Nepali version of the UNFPA/Save the Children ASRH toolkit for humanitarian settings. District-level orientations and trainings have started to familiarize health professionals, but coverage is as yet small.** UNFPA has contributed to developing the capacities of health service providers and other stakeholders such as central and district-level DRC members to ensure quality SRH services in emergencies and to implement MISP. Under the Health Cluster, Rapid Response Teams (RRTs) have been formed at national and regional levels, in all 75 districts of Nepal and at the community level. With UNFPA technical assistance and funding, EDCD developed an integrated RRT training package with a session on MISP. UNFPA has since supported EDCD trainings for RRT members. The evaluation team noted that participants were selected from UNFPA priority districts, but, at official request, also from other districts. UNFPA also worked with the NHTC to adapt the MISP training package in Nepali. A 3-day training package was endorsed in 2015 and rolled out to nearly 400 health service providers and stakeholders.

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<sup>232</sup> UNFPA Dignity Kit Programming Guidelines, HFCB/PD, January 2013.

UNFPA's work to introduce the toolkit "ASRH in Humanitarian Settings"<sup>233</sup> in Nepal began in 2013 in collaboration with the EDCD, FHD and Save the Children, with the support of NRCS. First orientations using a Nepali translation of the ASRH toolkit were conducted by NRCS in 2014. The toolkit was formally adopted by FHD in 2015 and has been implemented in 12 districts, including earthquake-affected ones. Participants were DHO officials, health service providers including from AFHS centres, FCHVs and HFOMC members. Besides such dedicated trainings, ASRH in humanitarian settings is also a standard component of MISP trainings.

UNFPA has worked closely with the DWC and NRCS to train officials, government health professionals and others in Kathmandu and the 18 priority districts on GBV in emergency situations: In 2014, with UNFPA's financial and technical support, 20 national protection cluster members and NRCS volunteers in Kathmandu were trained by the NRCS on protection and GBV issues in emergencies.<sup>234</sup> This was considered crucial. As a result, the leadership of the DWC in the protection cluster and collaboration with the NRCS reportedly improved. Since 2014, UNFPA has also strengthened the capacities of hundreds of health service providers and other stakeholders from DDCs, WCOs and local NRCS chapters to plan for and deal with GBV in emergency situations in its priority districts. In partnership with the DWC and NRCS, 56 persons from WCOs, DDCs and NRCS from 18 districts were trained in four-day training of trainers on protection issues in emergency and a total of 395 protection cluster members and stakeholders oriented on protection in emergencies in 18 UNFPA priority districts.

The evaluation team was unable to explore in-depth the extent to which UNFPA emergency preparedness trainings have increased knowledge and confidence or even made a difference in cases of emergency. However, available quantitative and qualitative evidence paints a positive picture. Knowledge of trained RRT members and other health service providers on SRH in humanitarian settings and MISP has increased. They feel increasingly prepared and confident to respond to emergencies. As for example health service providers in Sunsari remarked: "After participating in RRT orientation, we are more capable of responding to disasters". Similarly, health professionals from Sindhuli commended UNFPA-supported trainings for increasing their understanding and skills. Interviewees at the visited AFHS centres in Baitadi and Sunsari had benefited and were satisfied with the ASRH toolkit trainings, although they would have appreciated a more hands-on approach and were not in possession of the toolkit. No studies have been conducted to gauge the extent of knowledge gain thanks to UNFPA-supported trainings on GBV in humanitarian settings. Pre- and post-training results reveal imminent knowledge improvements. Interviews also pointed to increased knowledge.

**IND6.1.8 The importance of being able to continue delivering SRH and GBV services in times of crises is generally recognized and government systems and strategies are in place. However, further advocacy as well as support for capacity building and repositioning is necessary.** UNFPA's emergency preparedness programme has cut across the SRH and GE programme components to support planning, coordination, capacity development and repositioning. UNFPA's support was embedded in government structures, in collaboration with government authorities and international and local organizations. Evidence suggests that SRH and GBV are integral parts of emergency preparedness planning and coordination in Nepal, at central<sup>235</sup> and district levels – perhaps less so at VDC level. As such, sustainability of UNFPA's efforts is ensured, also in the knowledge that the CO does not intend to withdraw from the cluster system.

As regards trainings and orientations on MISP, A/SRH and GBV in humanitarian settings, a host of individuals have benefited and should be able to use their knowledge and skills should a disaster occur. RRT and MISP trainings have been institutionalized and are managed by the

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<sup>233</sup> Save the Children & UNFPA: Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings - A Companion to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, September 2009.

<sup>234</sup> In 2014, 20 protection cluster members and Red Cross volunteers were trained in GBV in humanitarian settings through three-day training.

<sup>235</sup> For instance, the DWC has allocated a budget for protection cluster meetings.

EDCD and NHTC, which bodes well for their sustainability. But most UNFPA-supported trainings were planned, funded and conducted in individual districts as part of AWP with UNFPA Implementing Partners, and are therefore on a more insecure footing.

The procurement and repositioning of sufficient dignity and RH kits and replenishment of stocks requires a continuous effort to be able to effectively and rapidly respond to small and large-scale emergencies. As the GoN cannot sustain this activity on its own, procurement by UNFPA and other development partners will be required.

#### A.6.2 UNFPA's response to humanitarian crises, particularly the April 2015 earthquake

**IND6.2.1&6.2.2 UNFPA was a key actor for providing post-disaster A/SRH services and information in the 14 earthquake-affected districts. A considerable number of vulnerable women and girls were reached thanks to UNFPA, including through mobile RH camps.** In 2015 the RRF was modified to include indicators and targets for UNFPA's earthquake response. Amongst others, indicators were added to track its support for the implementation of MISP in the 14 most-affected districts<sup>236</sup> and the number of persons, including women and girls, reached through RH kits and SRH services<sup>237</sup>. Monitoring data reveal that the CO outperformed itself, although support was modest compared with the number of affected persons and the huge demands in the affected districts - i.e., estimated 1.4m women of reproductive age, of which 93,000 were pregnant, 10,300 expected to deliver each month and 1,500 were at risk of obstetric complications.<sup>238</sup> Monitoring data reveal that UNFPA distributed a total of 1,331 RH kits and trained 163 health workers on their contents and use; an estimated 143,686 persons benefitted from drugs and supplies contained therein. UNFPA also organized 132 mobile (tent) RH camps. Mobile camps lasted for 2-3 days. They provided SRH and GBV services, information, drugs and contraceptives, hygiene articles, psycho-social counselling, and included special spaces for A&Y to receive advice and commodities. 8-10 youth volunteers per camp were trained to deliver information on ASRH inside and outside the camps. All in all, RH camps reportedly catered for 104,740 persons, 85% of which were women and adolescent girls; 10,293 people utilized UNFPA-supported FP services.<sup>239</sup> 5,000 A&Y visited the camps.

UNFPA also established transition homes (tents) where it reached 1,127 pregnant and postpartum women; it set up maternity tents and tents as birthing centres. Furthermore, to facilitate the continuation of community health services, UNFPA contributed some 3,000 motivational packages to FCHVs in three districts (Sindhuli, Okhaldhunga and Kathmandu). The content of the package - including a solar lamp, hygiene items, clothes, medicines and other basic supplies - was agreed upon in the RH sub-cluster.<sup>240</sup>

In 2015, UNFPA also expanded trainings on SRH in emergencies and MISP to earthquake-affected districts. Besides 163 health workers oriented on RH kits, 100 health service providers were trained on MISP.<sup>241</sup> UNFPA has continued to provide such trainings outside its priority districts, but at a limited scale.

In *Sindhuli* district, UNFPA enabled training for RRT members on disaster preparedness and response, including MISP and use of RH kits. RH and dignity kits were distributed and RH kit training provided to 90 health service providers from 24 health facilities. UNFPA and the DHO conducted 13 RH camps for those 25 VDCs identified by the DDRC to have been most affected, covering nearly 12,500 persons, of which 70% were women. The provision of FP services (mainly implant, IUCD and condoms) and sanitary pads, as well as psycho-social counselling along with medical treatment services proved relevant and effective. Dignity kits were

<sup>236</sup> CPAP Outcome 1 Output 1 Indicator 4.1.

<sup>237</sup> CPAP Outcome 1 Output 1 Indicator HFCB IRFI3.8.

<sup>238</sup> Nepal Earthquake 100 Days into the Humanitarian Response, p5-7.

<sup>239</sup> Source: UNFPA August 2016 monitoring data.

<sup>240</sup> [http://nepal.unfpa.org/sites/asiapacific/files/pub-pdf/UNFPANepalEQ\\_humanitarianresponsereport27August.pdf](http://nepal.unfpa.org/sites/asiapacific/files/pub-pdf/UNFPANepalEQ_humanitarianresponsereport27August.pdf).

<sup>241</sup> UNFPA monitoring data 2016.

distributed to pregnant and postpartum women as well as mothers with children under two years<sup>242</sup>. ASRH information and services were provided, including on the topic of human trafficking. UNFPA support was reportedly provided before other partners appeared on the scene. It proved itself as the main organization to support the health sector on RH and adolescent-friendly services. In *Gorkha*, a similar picture presented itself where UNFPA was considered the front-line organization for supporting SRH services. RH camps were conducted in ten different locations.

**IND6.2.3&6.2.5 UNFPA's support for protecting women and girls after the earthquake was largely in the form of coordination, procurement and trainings. It went beyond support for the health system and health services for GBV survivors. Female-friendly spaces were much appreciated. The distribution of 56,000 dignity kits was another important element of UNFPA's earthquake response, but some critical voices were raised in terms of quantities, contents and distribution mechanisms.** The modified RRF also included indicators and targets to track UNFPA's support for an effective health response to GBV during the earthquake<sup>243</sup> and the number of persons, including women and girls, reached with GBV services<sup>244</sup>. UNFPA's engagement in the emergency GBV response was largely in the form of coordination, procurement and trainings. The evaluation team noted that the organization's support for GBV services targeted women's health and well-being in a holistic manner, and not only through the health sector. Thus, UNFPA made available 14 FFSs (tents) to WCOs, one for each earthquake-affected district, as well as 55,000 dignity kits and 600 winterization packages for distribution through local governments, mobile RH camps and FFSs.<sup>245</sup> Through the DHO it provided 53 post-rape treatment kits to OCMCs and health facilities.

In the context of the aftermath of the Nepal earthquake, the DWC requested ten FFSs in each of the affected districts. The GBV sub-cluster of the Protection Cluster developed guidelines on FFSs, adapted from the UNFPA Female Friendly Spaces guidelines.<sup>246</sup> UNFPA-supported FFSs provided a multi-sectoral response to GBV survivors as well as SRH services, and intended to support the resilience and well-being of women and girls through community-organized recreational activities conducted in a friendly and stimulating environment.<sup>247</sup> Ultimately, the FFSs reached a total of 124,720 women and adolescent girls, an average of approximately 9,000 per district.<sup>248</sup> 427 GBV survivors were referred for various multi-sectoral services. Interviewed WCO officials in Sindhuli, Gorkha and Sindhupalchowk highly appreciated the FFSs, which they considered innovative and beneficial. It was suggested that coverage should be for entire districts and not only selected VDCs. The evaluation team visited the location of the FFS in Sindhuli. The FFS had catered for more than 750 earthquake-affected women and adolescent girls. The WCO and beneficiaries confirmed that it had made available dignity kits and counselling services as well as recreational space.



**FFS Beneficiaries in Sindhuli District**

<sup>242</sup> Later reduced to below two months when the kits were limited.

<sup>243</sup> CPAP Outcome 2 Output 1 Indicator 1.

<sup>244</sup> CPAP Outcome 2 Output 1 Indicator HFCB IRFI10.6.

<sup>245</sup> UNFPA August 2016 monitoring data.

<sup>246</sup> Guidance on Female-Friendly Spaces (FFS) – Nepal Earthquake Response (v.1).

<sup>247</sup> [http://nepal.unfpa.org/sites/asiapacific/files/pub-pdf/UNFPANepalEQ\\_humanitarianresponsereport27August.pdf](http://nepal.unfpa.org/sites/asiapacific/files/pub-pdf/UNFPANepalEQ_humanitarianresponsereport27August.pdf).

<sup>248</sup> UNFPA August 2016 monitoring data.

UNFPA has handed over 12 FFSs (tents) to WCOs and associated women cooperatives, including in Sindhuli, Sindhupalchowk and Gorkha; in 2016 it continued to support ten FFSs as part of transition and recovery efforts.<sup>249</sup> In Sindhuli, the evaluation team noted several problems: the cooperative lacks the space for storing the tent(s) and associated materials; members do not know how to set up the tent; they would like to use the tent(s) beyond emergency situations; they lack the capacity, staff and the means to manage and run a FFS in the event of a disaster. Similarly, the WCO in Gorkha was facing storage problems. Meanwhile, FFSs have been included in the National Protection Cluster Strategic Plan as a key response intervention. The MoWCSW has reportedly requested UNFPA to support the development of FFS operational guidelines.

The procurement of 56,000 dignity kits was another important element of UNFPA's earthquake response. Dignity kits were distributed to women who were pregnant, lactating, single, aged, disabled as well as women of reproductive age from more vulnerable groups. Planning and distribution were conducted in coordination with the DWC and WCOs.<sup>250</sup> One key informant and local respondents pointed out that, while dignity kits were greatly appreciated, the quantity distributed during the earthquake was insufficient. Another expressed concern that the kits reached earthquake survivors too late and that the distribution mechanisms needed evaluating. Indeed, with barely any options to procure locally due to the earthquake, as the evaluation team was informed by the UNFPA CO, and in the absence of a Long-term Agreement (LTA), UNFPA was obliged to procure dignity kits through a series of international bids. This, along with late receipt of some donor funds, indeed somewhat delayed procurement and distribution. Dignity kit contents had been determined based on the draft National Protection Cluster Strategic Plan.

UNFPA supported NHTC and CVICT to expand GBV-related orientations and trainings – i.e., psycho-social counselling and CMR - to the earthquake-affected districts. 113 psycho-social counsellors and other service providers and outreach workers were trained by CVICT to counsel GBV survivors in mobile RH camps, FFSs and through their community-outreach work.<sup>251</sup> 14,011 women and adolescent girls benefitted from such counselling services.<sup>252</sup> UNFPA-supported psychosocial counsellors have had a long-term impact; they are still providing services in the districts. Moreover, 261 health workers, designated to work in OCMCs and mobile RH camps, were trained to implement CMR.<sup>253</sup> It was estimated that more than 28,000 women and adolescent girls could require post-rape treatment.<sup>254</sup>

Last but not least, UNFPA IEC played an important part in the earthquake response cutting across SRH and GBV. Especially mobile RH camps played an important role in raising the population's awareness on FP and A/SRH through, for example, flipcharts and posters: monitoring data reveal that 56,496 persons were reached. Local FM radios were also used to spread awareness among survivors: in total, 7,803 episodes were aired to provide messages on SRH, GBV and ASRH.

**IND6.2.6 UNFPA participated in the Post-Disaster Needs Assessment, which influenced the official earthquake response, including in the areas of population, SRH and GBV.** After the April 2015 earthquake, the RRF was amended to include the indicator “# of districts experiencing a humanitarian crisis situation in which UNFPA provided TA on the use of population-related data and support for assessments”.<sup>255</sup> UNFPA contributed to two important assessments post-earthquake. As intended, the CO provided support to the NPC for conducting a

<sup>249</sup> Dignity First – UNFPA Nepal 12 Month Earthquake Report, July 2016.

<sup>250</sup> UNFPA August 2016 monitoring data; [http://nepal.unfpa.org/sites/asiapacific/files/pub-pdf/UNFPANepalEQ\\_humanitarianresponsereport27August.pdf](http://nepal.unfpa.org/sites/asiapacific/files/pub-pdf/UNFPANepalEQ_humanitarianresponsereport27August.pdf).

<sup>251</sup> 20 Psychosocial Counsellors, 14 Case Managers and 79 Psychosocial First Aid volunteers. Source: [http://nepal.unfpa.org/sites/asiapacific/files/pub-pdf/UNFPANepalEQ\\_humanitarianresponsereport27August.pdf](http://nepal.unfpa.org/sites/asiapacific/files/pub-pdf/UNFPANepalEQ_humanitarianresponsereport27August.pdf).

<sup>252</sup> UNFPA August 2016 monitoring data.

<sup>253</sup> UNFPA August 2016 monitoring data. The evaluation team was unable to meet trainees from the earthquake-affected districts and thus unable to respond to **IND6.2.4**: Trainee satisfaction with training on GBV services, including CMR.

<sup>254</sup> Nepal Earthquake 100 Days into the Humanitarian Response, p5-7.

<sup>255</sup> CPAP 2013-17 Outcome 3 Output 2 Indicator 2.1.

Post-Disaster Needs Assessment (PDNA), funded by the World Bank and UNDP. As core team member, UNFPA contributed to the PDNA in three sectors: (1) health and population; (2) gender, elderly, persons with disabilities and children’s welfare; and (3) Human Development Impact Assessment. UNFPA mobilized youth to collect primary data for the PDNA Human Development Impact Assessment field survey: it mobilized 42 youth in six districts to collect primary data from around 400 households. UNFPA’s involvement in the PDNA, the only document available for emergency programming, contributed to the integration of population/migration/displacement, SRH, GBV and social protection issues in the immediate response, recovery and reconstruction plans and strategies.<sup>256</sup> Importantly, the GoN utilized the PDNA in preparing the Post-Disaster Relief Framework. It was also used internally by UNFPA staff for planning earthquake-related activities such as FFSs and contraceptive supplies. Similarly, UNFPA, in collaboration with the International Office of Migration, supported a study entitled “Socio-demographic Impact of the Earthquake 2015” .

## 4.3 Efficiency

**EQ7 Financial and human resources: To what extent has UNFPA made good use of human and financial resources to pursue the achievement of CP7 outputs and outcomes?**

### A.7.1 Financial resources and CP7 implementation

**IND7.1.1 UNFPA applies a risk-based approach to financial management.** In 2011, the evaluation of CP6 found that: “Given UNFPA’s recent qualified audits, management and operations clearly feel the need to justify all expenditures in a transparent manner, and demonstrate accountability and value for money...”<sup>257</sup> Interviews in Kathmandu reaffirmed a continued alertness to financial risks. Thus, UNFPA in Nepal has introduced practical measures such as annual CO assessments, HACT implementation and delegation of more financial authority to Programme Managers who are closer to and more knowledgeable of their respective programme activities. In an environment where corruption in the public sector is rampant<sup>258</sup>, the CO is also considering the pros and cons of working with NGOs in lieu of government counterparts.<sup>259</sup> Mention was also made that physical presence in the districts is an effective risk mitigation measure. Those interviewees offering an opinion, from within and outside the organization, considered UNFPA finances to be managed transparently.

**IND7.1.3&7.1.4 UNFPA Implementing Partners have received funds in a timely manner, thanks to UNFPA’s attention to the matter and HQ’s accommodation of local needs. Despite difficult circumstances and uncoordinated fiscal years at the central level, implementation has been high – 92.2% for the period 2013-16.** Major factors that have in instances delayed the release and receipt of CP7 funds in Nepal are late reporting and planning, CO bottlenecks, channelling of funds to GoN IPs through the “Red Book”, and the Nepali banking system. In this respect, the UNFPA CO has introduced several measures to facilitate timely release and receipt. These include a more rapid processing of Funding Authorization and

<sup>256</sup> Dignity First: UNFPA Nepal Earthquake 12 Month Progress Report 2016.

<sup>257</sup> Evaluation of UNFPA’s Sixth Country Programme in Nepal (2008-2012), Final Report, November 2011, p51. According to the CO, mention is of an unsatisfactory internal audit conducted in 2014.

<sup>258</sup> Nepal further slipped on the Corruption Perception Index (CPI) 2015 of Transparency International, continuing its standing as one of the most corrupt states in the world. The annual survey placed Nepal in 130 positions with a score of 27 among 167 surveyed countries. Nepal failed to improve both country wise ranking and score. In 2014, it was placed 126th rank on the index among surveyed countries with 29 marks last year. The CPI measures the extent of corruption within a country on a scale ranging from zero to 100. Countries that score below 50 are perceived as highly corrupt and those that secure 100 are cleanest. Source: The Kathmandu Post (online edition), January 27<sup>th</sup> 2016.

<sup>259</sup> During CP6, audit issues prompted UNFPA to turn to large national and international NGOs based in Nepal. CPE CP6, p8.

Certificate of Expenditure (FACE) forms by delegating more authority to Programme Managers. They also include HQ's permission to release funds for six months rather than on the standard corporate quarterly basis because of poor banking services, which was found to have reduced implementation delays, to have helped align with the Nepali FY that runs from July 16<sup>th</sup>-July 15<sup>th</sup>, and to have lessened paperwork. Furthermore, the CO has worked towards improving the timeliness of reporting and planning. In the SRH programmatic component, multi-year planning was found to help decrease time spent on planning.

According to UNFPA staff, the CO also reduced collaboration with GoN IPs and increased co-operation with NGOs in order to circumvent the "Red Book", which is a cause of delays in funding authorization and disbursements, and consequently implementation. Atlas data (Annex 4) reveal that the number of NGO IPs has indeed increased considerably; but the number of GoN IPs that UNFPA deals with did not decrease. In 2013 UNFPA partnered with 4 NGO IPs; this rose to twelve in 2016, still less than half the number of GoN IPs. In 2016 UNFPA was directly collaborating with 29 GoN IPs, three more than in 2013 (26).<sup>260</sup> Limiting this analysis to collaboration with central-level IPs, UNFPA had 6 GoN IPs in 2013; in 2016 it dealt with 10. However, in monetary terms, collaboration with NGOs has become almost equally important: Collaboration with the GoN increased slightly: GoN NEX expenditures amounted to \$1.42m in 2013 and \$1.57m in 2016. At the same time, NGO NEX expenditures amounted to \$160,000 in 2013 and multiplied considerably (nearly eight-fold) to \$1.23m in 2016.

To the same intent – i.e., to facilitate timely receipt of funds by DDCs - the CO successfully negotiated the possibility of direct fund transfers to District Development Facilities besides through the "Red Book". Indeed, the overwhelming view, both at central and district levels, was that funds were generally been released and received on time. No differentiation was made whether for regular programming or for earthquake assistance.

Besides depending on timely receipt of funds, implementation of CP7 has been affected by the country's political situation, including frequent rotation of government officials. Implementation – e.g., of CSE or DPMAS - was physically hindered by the earthquake, border restrictions and strikes in 2015. Regular programmes were temporarily de-prioritized during the second half of 2015 in view of urgent humanitarian response and relief needs. Different FY cycles, especially of the GoN and UNFPA, were also frequently and mostly critically mentioned in the context of timely delivery. Previously, the CPE of CP6 had already found this inconsistency to affect implementation.<sup>261</sup> A practical and much appreciated solution has since been found at district level where, since 2014, AWP with DDCs follow the GoN FY. Public procurement – e.g., of emergency support materials - was a further reason for implementation delays.

Despite all challenges, interviews and Atlas data reveal a high level of implementation (Annex 4). In absolute terms, UNFPA utilization rose considerably from \$3.8m in 2013 to \$5.5m in 2014 and \$8.63m in 2015. The respective utilization rates were 82.8%, 96.5% and 98.6% or an overall utilization rate of 92.2%.

**IND7.1.2 Resource mobilization has become increasingly important in view of plunging annual RR spending ceilings. The RR/OR mix has changed. UNFPA has mobilized considerable Other Resources from a broad range of sources, including UNFPA Trust Funds, and particularly for SRH and GE. UNFPA has not only mobilized Other Resources for its own activities; it has leveraged additional funding from other development partners.** The UNFPA SP 2014-17 classified Nepal as a "red country". In red countries, where national need is recognized to be highest and ability to finance low, COs are expected to make use of all modes of engagement to achieve regular programming and humanitarian assistance objectives, including service delivery. As a red country and a country at risk of humanitarian

<sup>260</sup> Between 2013 and 2016, two DDCs (Kanchanpur and Surkhet) were phased out. UNFPA reverted to partnering separately with FHD, LMD, NHIECC, NHCT and EDCC of the MoH instead of having DoHS consolidate the five.

<sup>261</sup> "The different FY cycles of the GoN and UNFPA prevent adequate time for programme implementation by GoN, resulting in funds being under-utilised." CP6 CPE, p36.

crises, the SP envisages that Nepal should be allocated a higher share of RR.<sup>262</sup> The indicative RR commitment, according to the CPD, was \$23m for 2013-17 or a planning figure of \$4.6m per year. With only one more year to go, total RR spending ceilings, including ERF, have amounted to only \$16.62m and annual RR ceilings have dropped significantly (Table 14) from a peak of \$4.6m in 2014 to 4.05m in 2015 and 3.43m in 2016. The prospects for 2017 are even more precarious with the indicative ceiling just exceeding 50% of the original plan. Corporate austerity measures worry UNFPA Nepal staff; they put more pressure on the CO to raise OR.

**Table 14: Annual RR Spending Ceilings 2013-17 (in millions of US\$)**

	2013	2014	2015	2016	2017	Total
<b>Planned RR</b>	4.60	4.60	4.60	4.60	4.60	<b>23.00</b>
<b>RR Ceiling</b>	3.94	4.60	4.05	3.43	2.47 <sup>263</sup>	<b>18.49</b>
<b>Difference</b>	0.66	0	0.55	1.17	1.75	<b>4.13</b>

Source: UNFPA Nepal CO

Annex 4 reveals that the CO has been rewarded for its resource mobilization efforts, which have already raised more than anticipated in the CPD (\$7.5m). In 2015, the year of the earthquake, OR (\$4.90m) even surpassed the RR annual ceiling (\$4.05m). Overall, since 2013, staff have been able to raise \$8.8m for implementing CP7, largely in support of SRH and GE activities.<sup>264</sup> Other Resources have been mobilized from a range of sources: bilateral agencies (first and foremost Japan, UKAID and Switzerland), UN Trust Funds, other multilateral organizations and small contributions. UNFPA Trust Fund support for maternal health and contraceptive supplies, as well as the UNFPA ERF, were further important sources, amounting to \$2.7m, a third of all OR. In addition, the CO mobilized in-kind contributions, mainly FP commodities. The amount in dollar terms varied, but, for instance, in 2015 alone amounted to \$2.58m.

The evaluation team noted that OR have been mobilized in line with CP7 regular programming and earthquake assistance. Key informants emphasized this firmness, at the same time adding that they had consequently had to reject opportunities outside the priority districts.

Besides mobilizing OR, which figure in UNFPA's budget and financial reporting, CP7 has also motivated other development partners to contribute to achieve its and the GoN's objectives. This was clearly the case for the ASRH programme, which has leveraged support from UNICEF and Save the Children for ASRH training sites, health service provider trainings and AFHS centre certifications. Equally, the midwifery programme has attracted the attention of other donors, including GIZ, Real Medicine Foundation and International Medical Corps.

#### A.7.2 UNFPA priority districts and decentralized programming

The evaluation team was requested to gather opinions on UNFPA's district prioritization and district-level programming, especially in view of CO considerations to exit certain districts. It is worth noting that, during CP6 UNFPA expanded the number of its priority districts from six to 12 (2010) and 18 (2011), with the formal approval of the GoN. The selection of districts was guided by development indices<sup>265</sup> and the presence of other UN agencies.<sup>266</sup>

**IND7.2.1 Decentralized programming has its benefits, but UNFPA may have interpreted its focus on 18 priority districts too rigidly.** CP7 has supported system-level interventions<sup>267</sup> and decentralized programmes in 18 priority districts. Decentralized programming has its benefits

<sup>262</sup> Annex 4 of the SP 2014-17 on funding arrangements.

<sup>263</sup> Tentative figure for 2017.

<sup>264</sup> PD is most reliant on Regular Resources. Only \$200,000 were mobilized between 2013 and July 2016.

<sup>265</sup> CPAP: Districts making slow progress in achieving the goals of the ICPD.

<sup>266</sup> CPE CP6, pvii.

<sup>267</sup> System-level interventions have primarily, but not only, benefitted UNFPA's 18 priority districts. For example, EDCCD RRT trainings were provided to health professionals from the 18 districts, but also other districts. Similarly, UNFPA-supported NHTC MISP trainings.

in terms of supporting decentralization and local governance, in terms of putting the spotlight on specific issues, and enabling UNFPA and the GoN to demonstrate tangible results. Working through DDCs is a unique model that might be heavy, but fosters ownership. However, the question remained unanswered as to whether UNFPA was spreading itself too thinly.<sup>268</sup>

The evaluation team was informed that the CO has rigidly restricted its regular programme activities to the 18 priority districts; that this has, however, in certain instances proved somewhat disadvantageous, in terms of fundraising and joint programming. In comparison, UN agencies are not required to strictly limit their activities to the 23 UNDAF priority districts; UNICEF also takes a flexible approach to its 15 priority districts.<sup>269</sup> Looking ahead, those UNFPA staff members voicing an opinion felt that the CO should feel freer to implement activities outside its priority districts after careful consideration. Indeed, this self-perception is certainly correct for UNFPA's work plans with 18 DDCs. However, it does not hold true for a number of activities implemented in co-operation with central-level partners.<sup>270</sup> Moreover, in 2016, the CO continued working in earthquake-affected districts.<sup>271</sup>

**IND7.2.1 Looking ahead, UNFPA might consider downscaling before definitively exiting priority districts. Future decentralized programming will have to align with local-level reforms and restructuring; it should be more focused on greatest needs.** UNFPA key informants suggested that exiting priority districts – e.g., Dang and Dadeldhura – should be an option and should happen based on an assessment of relevant indicators and level of national ownership and institutionalization. However, scaling down might be the preferred way to go to sustain benefits. The biggest question mark surrounding the future of UNFPA's decentralized programming in Nepal is the pace and outcome of local-level government administrative reforms and restructuring. All things equal, there seemed to be a consensus within UNFPA that CP8 should not envisage collaboration with DDCs in more districts, as the GoN might prefer, but rather fewer. Furthermore, UNFPA/GoN district-level programmes could be more “diversified”, “targeted”, “in-depth”, “concentrated” and “context-specific”, no longer necessarily covering all four SP outcome areas.

#### A.7.3 UNFPA organizational structure, rules and procedures

**IND7.3.1 CP7 has been delivered with an insufficient number of fixed-term staff and unsatisfactory staffing levels. Because of corporate financial austerity measures, additional human resource capacities for implementing and monitoring projects have had to rely on external funding and support.** In Nepal, UNFPA's performance has been, and still is, considerably dependent upon service contracts holders, especially in the regions and districts.<sup>272</sup> In 2013, CO management requested fixed-term posts for selected functions performed by national staff on service contracts in Kathmandu, which HQ approved.<sup>273</sup> In connection with the UNFPA SP 2014-17 re-alignment exercise, UNFPA Nepal commissioned a Human Resources Alignment Exercise. The report found a very real risk of losing human resources who had been trained and were fully familiar with UNFPA's mandate and

<sup>268</sup> This question was already raised by CPE CP6.

<sup>269</sup> According to the UNICEF Nepal CPAP 2013-17 “...will prioritize at least 15 districts (and their municipalities and VDCs) considered to be the most vulnerable through a newly-designed Child Deprivation Index... Pending availability of funds, another set of disadvantaged districts and municipalities will be supported through selective programming...” p26.

<sup>270</sup> For instance, establishment of six ASRH training sites in six government hospitals across Nepal; ASRH trainings for health service providers from other districts; BCC activities with the NHEICC; distribution of post-rape treatment kits to OCMCs.

<sup>271</sup> For instance, trainings on ASRH toolkit in humanitarian settings in three earthquake-affected districts Ramechhap, Dolakha and Okhaldhunga; GBV clinical management master training of trainings in Okhaldhunga. Support for female-friendly spaces in Okhaldhunga, Dolakha and Sindhupalchowk. Also, the Swiss-supported Gender-based Violence and Response Project 2016-18 is being implemented in Okhaldhunga (besides the priority districts Udayapur and Sindhuli).

<sup>272</sup> As of July 2016: 35 service contract holders of a total of 78 staff members. Source: UNFPA Nepal Office Employee Status as of 1 July 2016.

<sup>273</sup> UNFPA Nepal Request for Approval of Fixed-term Posts for UNFPA Nepal CO, June 2013.

programmatic interventions; a risk of not attracting technically-qualified staff due to non-competitiveness of UNFPA job levels, salary and job security; and a real fiduciary risk of not adequately addressing recent audit findings particularly with respect to programme and financial oversight. Also in view of Nepal's status as a "red country" with the full package of interventions, the report recommended a number of new national posts and upgrades to some existing posts.<sup>274</sup> A request was submitted to the UNFPA Asia and Pacific Regional Office in August 2014 and further submitted to HQ in June 2015 after being asked to reduce the scope of the human resources alignment.<sup>275</sup> However, corporate financial austerity measures have put any re-alignment on hold; proposed realignments were not approved. Nevertheless, UNFPA Nepal was able to create new posts through additional service contracts that do not require approval from HQ - e.g., Midwifery Technical Officer, Harmful Practices Technical Officer, CSE Technical Officer and several GBV positions, all funded through earmarked funds.<sup>276</sup> It mobilized donor-funded UNVs and JPOs. At the same time - as forewarned - it was not able to retain and lost valuable staff members due to unsatisfactory terms and conditions of employment.

Most of the responses to questions about UNFPA's organizational structure in Nepal revolved around its decentralized structure, and especially the physical presence of District Programme Officers in the 18 priority districts, hosted by the DDCs. <sup>IND7.3.1</sup>**The placement of UNFPA District Programme Officers is clearly a meaningful and advantageous investment. One District Programme Officer per district is the perceived minimum, all things equal.** All interviewed UNFPA staff appreciated the presence of District Programme Officers despite some question marks because of UNFPA's limited resources. According to one interviewee, "District Programme Officers bring UNFPA closer to the people in need and to the responsible local-level authorities." More specifically, UNFPA district-level presence has served to:

- Facilitate alignment with local priorities;
- Strengthen advocacy and policy dialogue;
- Strengthen UNFPA's role in emergency preparedness and response;
- Ensure frequent monitoring and implementation support;
- Facilitate access to information;
- Motivate and encourage line agency representatives; and
- Mitigate financial risks.

All things equal - i.e., should UNFPA continue to implement decentralized "mini-programmes" covering all outcome areas - interviews suggest that one UNFPA staff member per district is the bare minimum. Ideas range from recruiting administrative assistants to unburden District Programme Officers from their administrative responsibilities and to improve UNFPA office presence to including district-level project staff in project proposals.

District Programme Officers are backstopped by one of three UNFPA RSOs. They work under the direct supervision of the concerned Regional Development Coordinator. Comments on the work and support of RSOs were only few. They suggest that the existence of technical expertise to resort to and of a coordination mechanism between the districts on the one hand and between the districts and the CO in Kathmandu on the other hand is important. However, it is important to ensure that coordination functions and that technical expertise is available on time and adds value to the competences of the District Programme Officers.

<sup>IND7.3.2</sup>**UNFPA Nepal has complied with corporate policies, guidance, rules and regulations. In some instances, it has helped create and improve them and has successfully lobbied for their adaptation to local circumstances.** For instance, the CO piloted the Minimum Preparedness Actions (MPAs) and contributed to the external review of the Guidance Note on Minimum Preparedness (IND7.5.2). After the 2015 earthquake, it provided written comments on the UNFPA SOPs in Humanitarian Settings. In other instances, it worked towards adapting them to the Nepali situation - e.g., regarding the release of funds to IPs every six months or

<sup>274</sup> Nepal CO HR Alignment Exercise 2014 Final Report, August 2014.

<sup>275</sup> UNFPA interoffice memorandum, 8 June 2015.

<sup>276</sup> UNFPA Nepal Office Employee Status as of 1 July 2016.

synchronizing AWP with the GoN FY for district-level IPs. The fact that the recently-introduced Global Programming System (GPS) allows for multi-year planning accommodates voices promoting longer-term planning.

Specifically on NEX and DEX, one key informant found both implementation modalities to be challenging and time-consuming, suggested that procedures were not very clear and that the CO needed a clearer strategy. Only few NGO Implementing Partners provided a view on UNFPA's financial and administrative rules and regulations, including NEX. Their experiences differed. The evaluation team could find no patterns.

#### A.7.4 Use of results-based management<sup>277</sup>

**IND7.4.1&7.4.2 The monitoring system has been strengthened in response to the evaluation of the 6th UNFPA country programme. Monitoring is a regular feature of CP7 implementation, especially at the activities and output level. For lack of district-level data, the CPAP Results and Resources Framework is often not a good basis for results-oriented planning, monitoring and reporting at the outcome level.** The CPE of CP6 concluded that UNFPA in Nepal ought to strengthen its M&E system.<sup>278</sup> The evaluation team is of the view that progress has been made and that a robust monitoring system, with some weaknesses, is in place. This was echoed by UNFPA staff. The evaluation team considers the RRF a decent basis for results-oriented work planning and monitoring. The RRF was modified twice: first, to align with the SP 2014-17 IRF and second, to include indicators for UNFPA's earthquake response. Modifications were made to outcome and output-level indicators. Outcome and output statements remained the same. The level of expected financial resources was adapted for each outcome.<sup>279</sup> Annex 9 offers some comments on the CP7 *regular programme* results statements and indicators. Generally speaking, the evaluation team noted that:

- A good attempt was made to limit the number of outputs and to identify baselines and targets
- Anticipated results are linked to the UNDAF results framework
- A number of output-level indicators measure changes at the outcome level
- Most planned outputs and outcomes are correctly located at the level of UNFPA's 18 priority districts
- However, representative outcome-level data for the 18 districts are often hard to come by
- Indicators are mainly quantitative in nature; they hardly say anything about qualitative aspects
- The bulk of UNFPA's emergency preparedness work – e.g., prepositioning - is not reflected in the RRF

With the support of the CO M&E Officer, and in collaboration with Implementing Partners, evidence-based planning has been done on an annual and even multi-annual basis; year-wise process indicators and milestones have been prepared. In principle, the level of available funding has been known at the time of planning, although UNFPA austerity measures have led to retrospective budget cuts in some instances.

Progress at the level of project activities and outputs has been regularly monitored and reported. At a more strategic level, internal programme reviews were conducted on a quarterly and annual basis. Annual review meetings were held around November-December. UNFPA has been flexible and taken corrective measures: monitoring data were considered during planning processes. Targets and milestones were revised based on monitoring visits, research studies and reviews. Monitoring at the outcome level was less evident to the evaluation team. Outcome-level monitoring was hampered by the lack of up-to-date official data, especially for selected RRF indicators for SRH and GE, and insufficient CO funding to invest in additional surveys.

<sup>277</sup> Evaluation matrix A.7.4: CP7 made sufficient use of results-based programming, management and monitoring to achieve expected results in the RRF. Unless otherwise mentioned, the analysis in this section is based on a group discussion on RBM with UNFPA CO staff members.

<sup>278</sup> CPE of CP6, p64.

<sup>279</sup> Annex 2: Results and Resources Framework (RRF) for Nepal (Aligned with New UNFPA Strategic Plan 2014-2017) (Aligned with 2015 Earthquake Response).

One of the greatest challenges faced during planning and monitoring with GoN Implementing Partners has been the offset GoN and UNFPA planning cycles.<sup>280</sup> As mentioned previously (IND7.1.4), a practical and much appreciated solution was found at district level where, since 2014, AWP with DDCs follow the GoN FY.

#### A.7.5 UNFPA's internal emergency preparedness and response

The Organizational Effectiveness and Efficiency (OEE) section of the SP 2014-17 IRF contains management elements that should enable the attainment of development results. OEE Output 1 reads as follows: "Enhanced programme effectiveness by improving quality assurance, monitoring and evaluation". Indicator 1.8 relates to UNFPA's corporate emergency preparedness: "Percentage of Country Offices in high-risk countries that have up-to-date humanitarian preparedness plans".

**IND7.5.1 UNFPA Nepal humanitarian preparedness plans for the CO and the three Regional Support Offices are available and up-to-date.** "UNFPA Nepal Contingency Plans" have been available since 2013. They have been updated every year and are available for the years 2014, 2015 and 2016-17. Since 2014, in addition to earthquakes and floods, UNFPA Nepal contingency plans are based on a scenario of civil disturbances. According to the most recent contingency plan, the objectives of UNFPA's emergency response in Nepal are: (1) Save lives and alleviate suffering by providing and/or ensuring access to SRH services to those most affected, including strengthening referral systems; (2) Prevent and respond to GBV by providing services, including psychosocial counselling/support and strengthening mechanisms; (3) Restore comprehensive SRH and psychological services by integrating disaster risk reduction and improving resilience; and (4) Engage youth and adolescents for emergency response. Amongst other things, the 2016-17 plan talks to the national legislative, policy and institutional framework and to existing coordination clusters. It presents the UNFPA CO internal coordination mechanisms, staff roles and responsibilities as well as human and financial resource mobilization arrangements. Furthermore, it commits UNFPA to provide humanitarian trainings to its staff members and determines logistics and prepositioning of supplies.

Given the diversity of Nepal, UNFPA RSOs are additionally expected to develop region-specific contingency plans building on scenarios relevant to the geography and specific risks.<sup>281</sup> Those for 2015 were made available to the evaluation team; they were being updated at the time of drafting this report.

**IND7.5.2 With some important exceptions related to emergency operations planning, staff capacities, procurement, and information management, UNFPA Nepal fares well on the Minimum Preparedness Actions Dashboard. The MPA implementation status was recently updated using revised corporate guidance.** UNFPA's MPAs were developed based on a pilot by the UNFPA Regional Office for Asia and the Pacific (APRO) in the Philippines, Indonesia and Nepal in 2013.<sup>282</sup> They are a set of ten actions that establish UNFPA's minimum emergency preparedness. The evaluation team was provided with an Excel sheet entitled "Country Dashboard – Implementation MPAs" dated August 2015. According to the Dashboard, the CO has continuously implemented the MPAs, although some actions, especially under MPA3 (emergency operations plan) and MPA10 (capacity development), were still in process and one had not started – i.e., the preparation of a LTA for procuring dignity kits.<sup>283</sup> Pending revised MPA Guidance from HQ, the CO had not updated its implementation status since August 2015. However, the revised guidelines were reportedly received in August 2016 and a webinar on the

<sup>280</sup> The GoN planning cycle follows a Fiscal Year based on the Nepali calendar (mid-July to mid-July); UNFPA follows the UN calendar (January-December).

<sup>281</sup> UNFPA Nepal Contingency Plan 2016-17.

<sup>282</sup> UNFPA Programme Division/Humanitarian and Fragile Contexts Branch & Asia Pacific Regional Office: Guidance Note on Minimum Preparedness, May 2014, p3.

<sup>283</sup> It was due by July 2016, but information about a possible global LTA for dignity kits influenced action.

subject organized by APRO in September. The CO's MPAs were subsequently updated and are ready to feed into the Strategic Information System (SIS).

An external review of the UNFPA Guidance Note on Minimum Preparedness was published in 2015.<sup>284</sup> Nepal CO staff members participated in a survey and interviews. The review noted some good practices and lessons learned from the earthquake emergency (Box 5). According to them, further action is required to familiarize and prepare all CO staff with humanitarian issues and their respective roles and responsibilities. Moreover, UNFPA Nepal needs to step up its programme information management and reporting capacities.

#### Box 5: Good Practices and Lessons Learned from UNFPA Earthquake Response

- In Nepal and Ecuador, UNFPA works not only with national authorities but also with local governments to support inclusion of issues related to UNFPA's mandate in their contingency plans and increase capacities.
- After participating in the inter-agency contingency planning, some UNFPA COs - among them Nepal and Ecuador - developed a UNFPA internal contingency plan, which ensures UNFPA's ability to deliver upon commitments with the inter-agency group.
- The inter-agency group focused its contingency plan on flood risk. Preparedness efforts, although initially inspired by a different threat, proved very helpful in quickly providing humanitarian assistance to the earthquake victims. In particular, coordination agreements and supply lists were very useful at the onset of the crisis.
- UNFPA had to respond in districts not targeted in its regular programme. Likely, UNFPA Nepal could quickly relocate field staff to initiate response in the new locations.
- At the onset of the emergency, staff on the humanitarian team knew what to do, while many other staff were unprepared. All staff members, not only those with preparedness responsibilities, should be familiar with humanitarian issues. The office should define in advance the roles and responsibilities needed during an emergency and prepare the staff accordingly.
- Programme information management and reporting quickly became a priority need that the CO was unprepared to meet.

Source: Guidance Note on Minimum Preparedness Review

**IND7.5.3 UNFPA humanitarian programming in the earthquake-affected districts had a dedicated and functioning results-based monitoring and reporting system.** After the April 2015 earthquake, UNFPA modified its RRF to include earthquake response indicators and targets across all three programme components. Indicators were set at the output level. They were aligned with UNFPA's corporate framework for humanitarian work.<sup>285</sup> UNFPA developed monitoring tools and an earthquake response monitoring framework, which it implemented during six months. More than 100 persons were trained to generate data. Monitoring data were collected, including through joint missions. A 100-days response report as well as 5-month and 6-month reports were prepared. A 12-month progress report was published.<sup>286</sup> The evaluation team had the respective monitoring data at its disposal.

## 4.4 UNFPA Contribution to UNCT Coordination in Nepal

**EQ8 UNCT coordination: To what extent has UNFPA contributed to the functioning and consolidation of UNCT coordination mechanisms?**

<sup>284</sup> Guidance Note on Minimum Preparedness Review, Findings and Recommendations, Draft, December 2015.

<sup>285</sup> Latest version not yet available to the evaluation team.

<sup>286</sup> UNFPA: Nepal Earthquake Response – 12 Month Progress Report 2016.

**IND8.1.1 UNFPA has been an active leader and contributor to UNCT coordination**

**mechanisms relevant to its mandate.** In Nepal, UNFPA leads the UNCT Youth Group. Together with UNDP, the CO co-leads the SDG Working Group. In the context of its GBV-related work, it co-leads with the Prime Minister's Office the UNDAF Outcome 3 Coordination Group ("vulnerable groups experience greater self-confidence, respect and dignity"). Furthermore, UNFPA has participated in the Gender Theme Group, the UN HIV Team, the Conflict-related Sexual Violence Group, and the Peace Support Working Group. In the context of its SRH programme, it contributes to the UNDAF Outcome 1 Coordination Group; in PD it participates in the UNDAF Outcome 5 Coordination Group.<sup>287</sup> UNFPA is also member of the UNDAF M&E Group. On the operations side, UNFPA participates in the Operations Management Team and its related working groups as well as the Harmonized Approach to Cash Transfer Group.

Qualitative evidence for UNFPA's contribution to UNCT coordination mechanisms is rather weak.<sup>288</sup> However, interviewees voicing an opinion were consistently of the view that UNFPA has played an active role in UNCT coordination mechanisms, be it as chair or participant. Particular mention was made of UNFPA's role in the UNCT Youth Group, the SDG Working Group and the UNDAF Outcome 1 Coordination Group. According to one key informant "UNFPA is one of the heavyweights... it gets 10 out of 10 points for inter-agency coordination".

**IND8.2.1&8.2.2 Evidence revealed a number of good examples of joint programming and joint programmes, above all in the areas of child marriage, GBV and adolescent health. UNFPA also partnered with other UN agencies to influence policy frameworks and standards.**

UNFPA has partnered with UNICEF on a number of occasions in the areas of child marriage, GBV and adolescent health. Amongst other things, the UNFPA CO supported a UNICEF-led process to develop a National Strategy to End Child Marriage by 2020. UNFPA was also involved right from the beginning in designing and promoting the SFSP, led by UNICEF. UNFPA was in charge of developing the GBV and SRH contents. Vice versa, UNICEF supported UNFPA's initiative to conduct the "Barrier Study", published in January 2015, which, as seen above, prompted the GoN to review existing certification criteria for public AFHS centres and to revise the national ASRH training package for health service providers. UNICEF also facilitated dissemination of findings and recommendations from the "CSE Review" among education sector partners.

UNESCO is since very recently a close partner in CSE. UNFPA has started to collaborate with UNESCO and UN Women under the umbrella of the Global Joint Programme for the Empowerment of Adolescent Girls and Young Women through Education. Nepal is one of the six first-phase countries of the global Joint Programme. The five-year Nepali Joint Programme, led by UNESCO, is entitled "Empowering Girls and Young Women through the Provision of CSE and a Safe Learning Environment in Nepal". Implementation is starting in five of UNFPA's 18 priority districts. UNFPA is in charge of CSE, particularly in schools, including the establishment of adolescent-friendly corners. The programme also intends to implement the SFSP mentioned above.<sup>289</sup> Earlier, UNESCO had supported the CSE Review, conducted under UNFPA's leadership.

The UNFPA CO has grounded important parts of its regular SRH work on WHO standards, notably in the areas of supplies (seven life-saving maternal/RH medicines from the WHO priority list) and midwifery (ICM-WHO standards). It collaborated closely with WHO to pilot National Guidelines on the Prevention of Cervical Cancer, to develop the District Health Information System (DHIS), and in connection with OCMCs.

<sup>287</sup> Source: UN Interagency Coordination Groups 10062016.

<sup>288</sup> The evaluation team was only able to meet representatives of three UN agencies and the RCO.

<sup>289</sup> Information brochure "Empowering Adolescent Girls and Young Women through the Provision of CSE and a Safe Learning Environment in Nepal", 2016.

Four other joint initiatives are worth mentioning that were implemented at the end of CP6 and beginning of CP7:

- Funded by the UN Peace Fund for Nepal (2011-12), UNFPA, UNICEF and others co-implemented a joint programme entitled “Ensuring Recognition of Sexual Violence as a Tool of Conflict in the Nepal Peace Building Process through Documentation and Provision of Comprehensive Services to Women and Girl Survivors”. The initiative continued beyond 2012 with advocacy activities and further efforts.
- Funded by the UN Trust Fund to End Violence against Women (2010-13), UNFPA worked with UNICEF and UN Women in four districts to implement the joint programme entitled “Multi-sectoral GBV Response at the District Level in Nepal”.
- In 2013, UNFPA collaborated with UN Women to conduct the study entitled “Tracking Cases of GBV in Nepal: Individual, Institutional, Legal and Policy Analysis”.
- Also in 2013, UNFPA collaboration with UNICEF, UNESCO, UN Women and others resulted in the endorsement by the NPC of a National Plan of Action for the Holistic Development of Adolescents.

**IND8.2.4 Interviewees were generally satisfied with inter-agency collaboration.** Examples of factors contributing to successful relationships are credibility because evidence-based; trust and mutual understanding; common issues/interests; and capable staff. <sup>IND8.1.2&8.2.3</sup>**Nobody was able to pinpoint any missed opportunities.**

## 4.5 Added Value of UNFPA in Development Cooperation and Humanitarian Assistance

**EQ9 UNCT added value: To what extent has UNFPA made good use of its comparative strengths to add value to Nepal’s development results?**

### A.9.1 UNFPA’s added value in development cooperation

**IND9.1.1 National and international partners alike voiced positive opinions on UNFPA’s added value in its regular programming in all programmatic components.** According to some, UNFPA’s technical expertise in SRH, including ASRH, CSE and family planning, was a clear comparative strength to further build on. Others highlighted UNFPA’s leading role in integrating GBV into the health system by bringing health and protection actors together. Yet again others appreciated UNFPA’s in-house statistical and analytical competences and its ability to argue based on evidence. Moreover, UNFPA was commended for its strong youth focus compared to other development partners.

More generally speaking, interviewees mentioned UNFPA’s good relationships with the authorities, which facilitate ownership and increase the likelihood of sustainability. Without providing details, they identified comparative advantages in IEC and advocacy. One close UNCT partner emphasized the benefits of UNFPA’s district-level presence for co-operating locally.

### A.9.2 UNFPA’s added value in emergency preparedness and response

**IND9.2.1 At the national level, UNFPA contributed to the 2013 National Disaster Response Framework. UNFPA has been playing a lead role in emergency preparedness in the areas of RH and GBV, within the cluster system and the Humanitarian Country Team.** 2015 proved that earthquakes remain a large-scale hazard throughout Nepal with the country located on an active seismic belt; 18 districts (of which six are current UNFPA priority districts) are particularly prone to floods.<sup>290</sup> Relief work following a major disaster in Nepal is guided by the 1982 Natural Calamity Relief Act. The July 2013 National Disaster Response Framework (NDRF), to which UNFPA also contributed, provides the strategic direction for all phases of

<sup>290</sup> HCT Contingency Plan Nepal: Earthquake, February 2016; HCT Contingency Plan Nepal: Floods, August 2016.

disaster management. It clarifies the roles and responsibilities of government and non-governmental agencies involved in disaster risk management in Nepal.

UNFPA plays a key role in two of the 11 clusters: UNFPA, together with UNICEF, co-leads the protection cluster, which is led by the DWC of the MoWCSP and the National Human Rights Commission (NHRC). With the DWC, it leads the GBV sub-cluster. Interviewed protection cluster members are unanimous that the protection cluster and GBV sub-cluster are functional<sup>291</sup>, and that UNFPA has been playing an active role. Most recently, UNFPA contributed to the elaboration of a National Protection Cluster Strategic Plan in line with the NDRF, which was endorsed and disseminated in November 2016. Together with FHD, UNFPA is also co-leading the RH sub-cluster under the Health Cluster, which is led by the MoH and co-led by WHO.

UNFPA is also an active player and well positioned in the HCT, which is led by the UN Humanitarian Coordinator. In 2016, the HCT prepared two contingency plans – one for earthquakes and another for floods.<sup>292</sup> Document analysis revealed that SRH, GBV and MISP are well reflected in the strategic objectives and indicators of both documents. To give a flavour, some key response interventions include FFSS, psychological support, dignity kits, post-rape treatment, and print and electronic GBV prevention messages.

**IND9.2.2& IND9.2.3 UNFPA successfully led the RH and GBV sub-clusters after the earthquake. It played an important coordination role at the district level.** After the devastating earthquake in April 2015, UNFPA successfully advocated for more support, resources and funding to address increased risks of sexual and GBV occurring caused by the ongoing crisis, and to establish a referral system to support GBV survivors' access to quality care including emergency contraception. The CO was instrumental in ensuring regular meetings of the RH and GBV sub-clusters and documentation of those meetings. To facilitate coordination during the acute emergency situation, it deployed RH and GBV coordinators to the three humanitarian hubs in Kathmandu, Gorkha and Sindhupalchowk districts.<sup>293</sup> Feedback from RH stakeholders on UNFPA's performance was generally positive. Interviewed health officials in Gorkha and Sindhuli applauded UNFPA's role as a frontline organization that showed strong presence on the ground, that helped to build national coping capacities, and that provided direct support to survivors of the deadly earthquake. One NGO Implementing Partner emphasized its satisfaction with UNFPA's leadership, timely communication, and information sharing, but voiced regret over perceived competition between UNFPA, UNICEF and WHO.

## Chapter 5: Conclusions and Recommendations

*This chapter presents the evaluation team's strategic and programmatic conclusions based on the assessment above and in view of designing the 8<sup>th</sup> UNFPA country programme for Nepal 2018-22. Strategic conclusions are overarching in nature; programmatic conclusions address individual programmatic areas and deal largely with the evaluation criterion effectiveness. Conclusions reflect the evaluation team's professional opinion on selected aspects of UNFPA's performance during the period under evaluation and are forward looking, leading up to recommendations for consideration by UNFPA.*

The following prioritized conclusions have been made against the background of plunging Regular Resources and no improvements in the CO staffing situation. They also assume continued high levels of political instability and vulnerability to disasters. They are based on the assumption that the state restructuring process will remain delayed.

<sup>291</sup> UNFPA has achieved its target: the re-aligned CP7 RRF envisaged by the end of 2017 the GBV Working Group under the protection cluster would be functional (Outcome 2 Output 2.1 Indicator 2).

<sup>292</sup> HCT Contingency Plan Nepal: Earthquake, February 2016; HCT Contingency Plan Nepal: Floods, August 2016.

<sup>293</sup> CPAP 2013-17 Outcome 1 Output 1 Indicator HFCB IRF15 & CPAP 2013-17 Outcome 2 Output 1 Indicator 2. UNFPA August 2016 monitoring data.

## 5.1 Strategic Conclusions

### **Conclusion 1: The UNFPA CO needs to anticipate changes in the state structures.**

In 2015 the parliament ratified a new constitution. The GoN has a constitutional commitment to federalise Nepal. This is expected to make government more efficient and receptive to the needs and demands of the people. The long-awaited reforms, when they materialize, will require changes to UNFPA's organizational structure and to the way it has been co-operating with its government counterparts in Nepal, especially at the local level; they will generate a need for new datasets and analyses as well as for institutional capacity building. However, stakeholders have different views and opinions and clarity has not yet been established on the timeframe and roadmap for the reforms and the future of the current 75 districts under the new federal provinces provisioned by the 2015 constitution: will the current number and borders of districts be left intact? Will and, if so, how will current DDCs and district line agencies such as DHOs and WCOs be replaced? How will reforms affect responsibilities and mechanisms for policy and planning, service delivery and monitoring?

**Origin: EQ1, EQ3, EQ4, EQ5 and EQ6**

### **Conclusion 2: More needs to be done to bridge the data gap.**

UNFPA, alongside other development partners, has invested a lot in data generation and databases in all areas of its mandate. Thanks to its advocacy and technical/financial assistance, consciousness about the value of data and evidence-based planning is there, but the availability of up-to-date and adequately-disaggregated data is still a challenge in all spheres of UNFPA's work, *especially for the sub-national level*. This will affect GoN and UNFPA priority-setting, planning, monitoring, trends analysis and projections. More needs to be done to bridge the data gap, also in view of achieving the SDGs.

**Origin: EQ1, EQ3, EQ4 and EQ5**

### **Conclusion 3: The UNFPA CO needs to consider targeted efforts to benefit and empower very young adolescents aged 10-14.**

Adolescents and youth have been mainstreamed throughout CP7. However, CP7 was not realigned to target the specific needs of very young adolescents (10-14) and especially very young adolescent girls, a UNFPA corporate priority since 2014 and highlighted in the 2013 National Plan of Action on the Holistic Development of Adolescents. The CO is not alone: only 6% and 5% of UNFPA COs have identified and supported very young adolescent girls and boys respectively.<sup>294</sup> Indeed, many very young adolescent girls in Nepal are discriminated against by their own families – e.g., they are forced to drop out of school; they are married off early; they are particularly vulnerable during crises and disasters. This has multi-dimensional effects on their health and well-being. As adolescents aged 10-14 years are in their formative years, this is the right age to challenge traditional norms that compromise their rights to health care, education, recreation and their choices regarding marriage, profession and family life. There is need for action. It is insufficient to assume that very young adolescents will benefit; special efforts are necessary.

**Origin: EQ1, EQ3 and EQ4**

### **Conclusion 4: UNFPA should be more explicit on types of and expected contributions to emergency preparedness.**

Nepal is highly vulnerable to natural disasters. At the time of writing, a 5.5-magnitude aftershock struck near Mount Everest. UNFPA has been an active player at the centre and in its priority districts where it has made a difference in terms of incorporating MISP, A/SRH and GBV in Disaster Preparedness and Response Plans, strengthening coordination and the cluster approach in RH and GBV, building capacities and prepositioning supplies and

<sup>294</sup> Evaluation of UNFPA Support to Adolescents and Youth 2008-2015.

commodities. However, this important work was not sufficiently reflected in the CPD or CPAP 2013-17, especially in the RRF, and not reported and accounted for, also because the SP 2014-17 IRF is only a partial reflection of what UNFPA contributes.

**Origin: EQ6**

**Conclusion 5: UNFPA Nepal should reduce its number of priority districts and concentrate more.**

UNFPA's regional and district presence allows for focus and synergies; it generates concrete local experience for feeding into national policy dialogue and systems strengthening. However, after having increased the number of programme districts from six to 12 to 18, the UNFPA Nepal CO is rightly reconsidering its decentralized programming modality. It is considering leaving districts that have reached certain benchmarks and more thematic concentration of limited funds within the remaining ones. Some staff are entertaining the idea of more flexibility in terms of accepting direly needed Other Resources for activities outside its priority districts.

**Origin: EQ7**

**Conclusion 6: The UNFPA CO should be clearer on its expectations of adolescents and youth participation and the outcome of its efforts.**

Youth participation in DDC council and DIPC meetings has shown a positive trend – although according to available data mainly young men and those not belonging to disadvantaged groups. UNFPA can take credit. While this increase per se constitutes progress, CP7 is neither explicit on nor does it track the expected outcome of UNFPA-supported youth participation. Is it increased attention to and investments in young people's development in a broader sense or limited to SRH issues, which are specifically of interest to UNFPA, and which the CO is also influencing through other means and channels? The CP logic would suggest the latter.

**Origin: EQ1**

**Conclusion 7: The UNFPA CO should strengthen outcome monitoring.**

The UNFPA CO has gone to great lengths to have a robust and workable RRF. However, an important challenge has been identified concerning the selection of and level at which to pitch RRF outcome indicators. *Selection:* Data need to be collected frequently enough and at reasonable cost and effort to be useful for decision-makers; otherwise an indicator is not appropriate. For outcome indicators, this would ideally be on an annual basis in order to align with annual reviews. *Level:* In Nepal, UNFPA intends to make a countrywide difference, with special emphasis on selected districts. The current practise to pitch some outcome indicators at national level and disaggregate others at the level of the 18 priority districts is unsatisfactory and requires refining. While in most cases UNFPA contribution is most likely and easier to establish at district level, data on a range of topics have been unevenly available. However, in a country like Nepal, and with the CO's limited resources, the gap between UNFPA outputs and national outcomes is often (too) big.

**Origin: EQ7**

## 5.2 Programmatic Conclusions

**Conclusion 8: The UNFPA CO should better coordinate its behaviour change activities.**

Besides reforming the policy framework and strengthening state systems and their capacities, UNFPA has rightly worked in different ways to promote social and behaviour change and better utilization of services among women, men, adolescent girls and boys, parents and communities in order to achieve positive SRH outcomes. Good experience has been gained through inter-personal communication – e.g., mobilizing adolescent girls' circles and

orienting/training FCHVs, religious leaders, LGCDP social mobilizers and women cooperative members. UNFPA and the NHEICC also produced and distributed BCC materials, albeit insufficient in number. Recently they developed a BCC Strategy and Implementation Plan for 2016-17. This step towards a more programmatic approach is promising. However, it is unclear how the strategy and plan align with and support UNFPA-supported inter-personal communication activities to maximize message penetration and synergies.

**Origin: EQ3, EQ4**

**Conclusion 9: The UNFPA CO should continue to invest in midwifery.**

CP7 expected to contribute to an increase in births attended by SBAs in order to improve maternal health. In actual fact, this outcome ended up not being a major focus. At the same time, but in the same vein, the CO and its partners continued to considerably invest time in promoting midwifery – i.e., a separate education programme and official recognition of midwives - where it finally has concrete results to boast of. Midwifery is now formally recognized by the GoN as a separate profession. However, improving institutional and personal skills of a profession requires a large investment of time and effort.

**Origin: EQ3**

**Conclusion 10: UNFPA should focus its support for GBV services on health response.**

The GoN has committed itself to promoting gender equality and empowering women by ratifying various conventions at the international level and by formulating acts, policies, strategies and action plans at the national level. Relevant government mechanisms for GE identify with the policies. Yet within the wider structure of the GoN only little priority is given in terms of planning, budgeting and implementation. UNFPA's implementation support has been multi-sectoral: it has worked with its traditional partners in the health system and extended its co-operation to gender equality mechanisms. There is unfinished business on both fronts: more OCMCs and health professionals that provide quality services; safe houses that are professionally run; psycho-social counsellors that work in remote and distant areas; and quality FFSs that are locally-managed in times of emergencies. Continuous data generation, evidence- and rights-based advocacy as well as institutional capacity building and training for service providers are still required for tackling GBV within the overall GE and reproductive rights context. However, UNFPA cannot be in all places at the same time.

**Origin: EQ4**

**Conclusion 11: UNFPA should continue to prioritize the phenomenon of child marriage.**

UNFPA Nepal has heavily engaged in fighting child marriage. Indeed, data show a rising age at first marriage, although less so among girls who are least educated, poorest and living in rural areas. Also, there seems to be a gap between attitudes (high awareness) and behaviour (over a third of Nepali girls are married before the age of 18). To a lesser extent, UNFPA has also supported community-based mechanisms to address harmful practises such as chhaupadi (exclusion from the family during menstruation), dowry, witch hunting and son preference. Activities to this end and outcomes were less visible. While scaling up work to end other harmful practises would be very important, it would be premature to shift scarce resources and attention away from child marriage where there is considerable unfinished business.

**Origin: EQ4**

**Conclusion 12: UNFPA should further strengthen parliamentarians' commitment to and engagement in sexual and reproductive health and rights.**

Parliaments have a role to play in the development agenda. The UNFPA CO, under CP7, initiated co-operation with the National Forum for Parliamentarians on Population and Development (NFPPD), which has shown first important results. Partnering not only with the executive, but also with the legislative branch can be of added value for the entire UNFPA

country programme, especially in terms of influencing and leveraging national and sub-national laws, policies and the currently shrivelled national budget for population, SRH, youth and GBV that go beyond single ministries and demand stronger domestic accountability.

**Origin: EQ5**

## Chapter 6: Recommendations

*This chapter presents the evaluation team's strategic and programmatic recommendations for CP8 following from the conclusions drawn in the previous chapter.*

### 5.1 Strategic Recommendations

*Recommendation 1 on State Restructuring:* UNFPA will need to anticipate and flexibly respond to the political transition to ensure continued relevance and effectiveness. In view of uncertainties around state restructuring, UNFPA CO senior management should initiate an internal scenario planning process, with the participation of UNFPA Regional Development Coordinators, to think about the future, how the future might unfold, and how this might affect UNFPA's organizational structure and influence its programme priorities, modes of engagement and partnerships.

*Recommendation 2 on the Data Gap:* In view of UNFPA's recognized role as a key player in population and housing censuses and SP 2013-17 Outcome 4 Indicator 1, the PD component of CP8 should prioritize support for GoN planning, implementation, monitoring, dissemination and use of the next Population and Housing Census in 2021. Interventions should take into account findings and recommendations of the recent evaluation of UNFPA Support to Population and Census Data to Inform Decision-making and Policy Formulation 2005-2014.

*Recommendation 3 on the Data Gap:* As member of the Global Civil Registration and Vital Statistics Group and in the context of the Global Civil Registration and Vital Statistics Scaling Up Investment Plan 2015-2024<sup>295</sup>, the UNFPA CO (PD Team) should explore opportunities with HQ, the GoN and international partners such as the World Bank for UNFPA technical assistance for strengthening the CRVS system, particularly for facilitating the analysis and use of CRVS-generated vital statistics for local planning and decision-making.

*Recommendation 4 on the Data Gap:* GoN and UNFPA planning, monitoring and decision-taking regarding ASRH has been rendered difficult by the recently-overhauled HMIS that only offers data along indicators for the broad age cohort 15-49. The UNFPA CO (SRH Team) should advocate with the MoH and provide technical support, including training at all government levels, for incorporating disaggregated ASRH indicators and data in the government reporting system. Revised reporting should capture the status and essential health services provided to very young adolescents (10-14) and older adolescents (15-19), male and female.

*Recommendation 5 on Very Young Adolescents:* As part of CP8 preparations, and in consultation with selected partners such as UNICEF, UNFPA Nepal should commission/use analyses and explore opportunities to strengthen the participation and targeting of very young adolescents.

*Recommendation 6 on Emergency Preparedness:* The clustered country programme evaluation of UNFPA's engagement in highly-vulnerable situations (CCPE), led by the UNFPA Evaluation Office, should review IRF indicators to better reflect the different types of UNFPA contributions to emergency preparedness in its programme countries.

*Recommendation 7 on Emergency Preparedness:* UNFPA Nepal senior management should ensure that the CPD and CPAP 2018-22 speak more to Nepal's vulnerability, first and foremost to earthquakes and floods, but also to the consequences of frequent civil disturbances that disrupt services and distribution of supplies. The RRF should better reflect outputs in A/SRH, GE and PD that are expected to contribute to improved emergency preparedness.

<sup>295</sup> <http://unstats.un.org/unsd/demographic/CRVS/GlobalCRVS.html>;  
<http://www.worldbank.org/en/topic/health/publication/global-civil-registration-vital-statistics-scaling-up-investment>.

*Recommendation 8 on Decentralized Programming:* UNFPA's decentralized programme component should be maintained. But in view of positive development outcomes and limited resources it should be scaled down. CP8 should be implemented with special emphasis on a reduced number of priority districts within its current geographical clusters. UNFPA CO senior management should review UNFPA's priority districts against ICPD and relevant SDG goals and plan its complete or partial exit from individual districts. To the extent possible, the CO should continue to direct Other Resources to its priority districts. However, depending on donors' own strategies and priorities, UNFPA should be more open than in the past to selective programming in other disadvantaged areas, without contracting further DDCs as Implementing Partners.

*Recommendation 9 on A&Y Participation:* It is not clear what UNFPA's support for youth participation has resulted in. CP8 should be more clearly targeted towards and track the contribution of its support for youth participation to advancing UNFPA's mandate and ICPD priorities within the SDG context.

*Recommendation 10 on Monitoring:* CP8 RRF outcome indicators should be located at the national or district-level depending on the importance and scale of UNFPA's assistance and the availability/collectability of data. While the contribution of a wider group of partners is usually essential, outcomes need to be seen as having a significant and credible relationship with UNFPA outputs, otherwise their degree of ambition needs to be lowered.

## 5.2 Programmatic Recommendations

*Recommendation 11 on BCC:* UNFPA Nepal CO staff involved in knowledge generation and attitude/behaviour change (SRH Team, GE Team, Communication & Advocacy Officer) should form an internal BCC working group to ensure optimal coordination and integration of different A/SRH, GBV and child marriage-related BCC activities and partners.

*Recommendation 12 on Maternal Health:* Midwifery – i.e., developing and coaching a cadre of professional midwives who provide comprehensive maternity services and help prevent emergencies from occurring, even in remote areas, should continue to be a major UNFPA priority in line with the National Health Policy. In view of declining Regular Resources, UNFPA Nepal (SRH Team) should concentrate on convening and coordinating stakeholders and leveraging financial support.

*Recommendation 13 on GBV Services:* In view of scarce resources, the CO ought to concentrate its Regular Resources on its original mandate where it has an added value. As already envisaged in the CP7 RRF, this is the health response. Under CP8, the UNFPA Nepal CO (GE Team) should continue to focus on GBV, but with a stronger and more unique focus on the public health system's contribution to protecting and caring for GBV survivors, both in its regular programming, including emergency preparedness, and humanitarian response. UNFPA should mobilize others and increase the pool of actors to fill gaps in view of establishing a functioning referral system. Based on an assessment of psycho-social counselling and safe houses, it should mobilize and leverage Other Resources for strengthening the referral system.

*Recommendation 14 on Child Marriage:* The UNFPA Nepal CO (GE Team) should continue to emphasize the prevention of child marriage, now legally defined as a marriage entered into by an individual before reaching the age of 20 (as opposed to 18 at the outset of CP7). CP8 should be more explicit on the driving factors that override knowledge, positive attitudes and national legislation. Simultaneously, during CP8, the CO should strengthen the groundwork for UNFPA and other partners to tackle other harmful practises in an evidence-based and results-oriented manner, and from a human-rights point of view.

*Recommendation 15 on Legislative Support for SRH:* The UNFPA Nepal CO should strengthen collaboration with the NFPPD by facilitating increased participation of parliamentarians in national and international events and forums on interlinkages between population, SRH, gender and GBV issues; and building the capacities of parliamentarians to fulfil their legislative and oversight roles.