Country Programme Evaluation
UNFPA Tajikistan Country Programme 2010-2015 Evaluation Report
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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
AR	UNFPA Assistant Representative
ASRH	Adolescent sexual and reproductive health
AWP	Annual Work Plan
BSB	Biennial Support Budget
BTN	WHO Beyond the Numbers Initiative
CAT	Committee against Torture
CCP	Cervical cancer prevention
CD	UNFPA Country Director
CO	UNFPA Country Office
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CLMIS	Contraceptives Logistics Management Information System
CP	UNFPA Country programme
CPAP	UNFPA Country Programme Action Plan
CPAP MEC	CPAP Monitoring and Evaluation Calendar
CPAP PTT	CPAP Planning and Tracking Tool
CPD	UNFPA Country Programme Document
CPE	UNFPA country programme evaluation
CRC	Convention on the Rights of the Child
CSB	UNFPA Commodity Security Branch
CSW	UN Commission on the Status of Women
CWFA	Committee on Women and Family Affairs
DEX	Direct execution
DFID	UK Department for International Development
DHS	Demographic and Health Survey
EDN	Natural Movement of Population software
EECARO	UNFPA Eastern Europe and Central Asia Regional Office
EmOC	Emergency obstetrics care
EPC	Effective perinatal care
EQ	Evaluation question
ERG	Evaluation Reference Group
FP	Family planning
GBV	Gender-based violence
GDP	Gross Domestic Product
GE	Gender equality
GTG	Gender Theme Group
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GII	Gender Inequality Index
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
HDI	Human Development Index
HDR	Human Development Report
HFCB	UNFPA Humanitarian Fragile Context Branch
HIV	Human Immuno-deficiency Virus
HQ	Headquarters
ICD	International Classification of Diseases
ICM	International Confederation of Midwives
ICPD	International Conference on Population and Development

ICPD PoA	ICPD Programme of Action
IEC	Information, education and communication
ILBD	WHO International Live Birth Definition
IMPAC	WHO Integrated Management of Pregnancy and Childbirth
IP	UNFPA Implementing Partner
IPPF	International Planned Parenthood Federation
IPPFEN	International Planned Parenthood Federation European Network
IUD	Intrauterine device
LSIS	Living Standards Improvement Strategy
M&E	Monitoring and evaluation
MCH	Maternal and child health
MDG	Millennium Development Goal
MEDT	Ministry of Economic Development and Trade
MH	Maternal health
MICS	Multiple Indicator Cluster Survey
MISP	Minimum Initial Service Package for Reproductive Health in Crisis Situations
MMR	Maternal mortality ratio
MoE	Ministry of Education
MoH	Ministry of Health
MoHSP	Ministry of Health and Social Protection
MoU	Memorandum of Understanding
MSM	Men who have sex with men
NDS	National Development Strategy
NEX	National execution
NGO	Non-governmental organization
NHS	National Health Strategy
ODA	Official Development Assistance
OECD	Organization for Economic Cooperation and Development
OECD DAC	OECD Development Assistance Committee
OMT	Operations Management Group
OP	WHO Orientation Programme on Adolescent Health for Health-Care Providers
OR	UNFPA other resources
OSCE	Organization for Security and Cooperation in Europe
PCA	Programme Coordination and Assistance
PD	Population and development
PHC	Primary health care
PMTCT	Preventing of mother to child transmission of HIV
PWID	People who inject drugs
RAC	Republican Aids Centre
REACT	Rapid Emergency Assessment & Coordination Team
RH	Reproductive health and rights
RHC	Reproductive health centre
RR	UNFPA regular resources
RT	Republic of Tajikistan
SBAA	Standard Basic Assistance Agreement
SDC	Swiss Agency for Development and Cooperation
SDC/PDV	SDC Prevention of Domestic Violence Project
SDG	Sustainable Development Goal
SPR	UNFPA Standard Progress Report
SP	UNFPA Strategic Plan
SRH	Sexual and reproductive health

STIs	Sexually-transmitted infections
SW	Sex worker
TFPA	Tajik Family Planning Alliance
TMA	Total Market Approach
ToR	Terms of Reference
ToT	Training-of-Trainers
TWG	Thematic Working Group
RO	UNFPA Regional Office
RR	UNDP Resident Representative
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCG	United Nations Communications Group
UNCT	United Nations country team
UNDAF	United Nations Development Assistance Framework
UN-DESA	UN Department of Economic and Social Affairs
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNJAP	UN Joint HIV Advocacy Project
UNSD	United Nations Statistics Division
UNTFHS	UN Trust Fund for Human Security
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UPR	Universal Periodic Review
USAID	United States Agency for International Development
VAW	Violence against women
VCT	Voluntary counselling and testing
VSR	Victim support room
WAVE	Women against Violence Europe
WHO	World Health Organization
YFHS	Youth-friendly health services

KEY FACTS TAJIKISTAN

Land	
Geographical Location	Central Asia
Land area	142,600 square kilometres (1)
Terrain	93% of the country covered by the massive mountain systems of Central Asia
People	
Population	8,16 million (01/01/2014) (1)
Population growth rate (average annual %)	3.5%-2.1% (1980-2010) (3)
Urban population	26.6% (2012) (5)
Net migration rate	-1,17 migrants/1,000 population (4)
Age structure	0-14 years: 33% (4) 15-24 years: 20.1% (4) 25-54 years: 38.9% (4) 55-64 years: 3.2% (4) 65 years and over: 3.2% (4)
Government	Republic (constitution adopted 1994)
Key political events	Independence since 9 September 1991
Seats held by women in national parliament	17.5% (2013) (2)
Economy	
GDP per capita 2011 PPP USD	2,300 (4)
GDP growth rate	7.5% (2012) (1)
Income level	Low income[1]
Main industries	Aluminium, agriculture, natural resources, hydropower, retail trade, services
Social indicators	
Human Development Index (HDI) and rank	Index 0.607; Rank 133 (2013) (2)
Poverty rate	38.3% (2012)[2]
Unemployment	2.5% (2013) (1)
Life expectancy at birth	Male 70,9 (1) Female 74,1 (1)
Under-5 mortality (per 1,000 live births)	43 (3)
Maternal mortality ratio (deaths of women per 100,000 live births)	33,3 (1)
Health expenditure (% of GDP)	1.7% (1)
Birth rate	24.99 births/1,000 population (4)
Births attended by skilled health personnel	87% (3)
Sex ratio	At birth: 1.05 male(s)/female (4) Total population: 0.99 male(s)/female (4)
Fertility rate total (live births per woman)	6.3-3.2 (1990-2012) (3)
Adolescent fertility rate (births per 1,000 women aged 15-29)	42,8 (2013) (2)[3]
Abortion rate women aged 15-49	9% (3)
Condom use to overall contraceptive use among currently married women 15-49 years old	2% (3)
Contraceptive prevalence rate	28% (3)
Percentage of women who have knowledge about modern	83.2% (95.1% of married) women (3)

[1] http://data.worldbank.org/country/tajikistan.
[2] Annual Report 2012, Ministry of Economic Development and Trade (MEDT).
[3] According to the http://mdgs.un.org/unsd/mdg/Data.aspx, it was 54 in 2011.

methods of contraception	
Unmet need for family planning (% of women in a relationship not using contraception, but who wish to postpone the next birth (spacing) or stop childbearing altogether (limiting)	23% (3)
People living with HIV, 15-49 years old, person	Male: 3,421 (RAC 2013) Female: 1,217 (RAC 2013)[4]
Rate of newly diagnosed HIV infections (per 100,000 population)	15 (RAC 2013)[5]
Adult literacy (% aged 15 and above)	Male: 96% (2013) (1) Female: 98% (2013) (1)
Total net enrolment ratio in primary education	Boys: 99.5% (3) Girls: 95.7% (3)
Gender Inequality Index (GDI) and rank	Index 0,383; Rank 75 (2013) (2)
Gender-based violence (% women aged 15-49)	19% (3)
Refugees and others of concern to UNHCR	7,651 (end 2011) (5)
Participation in labour market	Male: 75.1% Female: 57.4% (2)
Millennium Development Goals (MDGs): Progress by Goal[6]	
1 Eradicate Extreme Poverty and Hunger	Very likely to be achieved, on track
2 Achieve Universal Primary Education	Very likely to be achieved, on track
3 Promote Gender Equality and Empower Women	Possible to achieve if some changes are made
4 Reduce Child mortality	Off track
5 Improve Maternal Health	Off track
6 Combat HIV/AIDS, Malaria and other Diseases	Possible to achieve if some changes are made
7 Ensure Environmental Sustainability	Insufficient information
8 Develop a Global Partnership for Development	Insufficient information

References

(1) Statistical Agency, www.stat.tj.

(2) Human Development Report 2014: Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience, UNDP.

(3) Tajikistan Demographic and Health Survey (DHS), 2012.

(4) CIA World Factbook, last updated in April 2014, https://www.cia.gov/library/publications/the-world-factbook/geos/ti.html.

(5) UN Data Retrieval System, accessed 14 May 2014, http://data.un.org/CountryProfile.aspx?crName=TAJIKISTAN

[4] Data for 1991 until 1 July 2013, Republican Aids Centre (RAC).

[5] http://nc-aids.tj/statistika.html.

[6] http://www.mdgmonitor.org/country_progress.cfm?c=TJK&cd=762, accessed May 2014.

EXECUTIVE SUMMARY

Background

This report is the result of an external evaluation of the UNFPA 3rd country programme (CP) in Tajikistan 2010-2015. The CP has three programmatic areas: reproductive health and rights (total expenditures of $3,80mio), population and development (total expenditures of $0.66mio), and gender equality (total expenditures of $0.59mio). The reproductive health and rights area is implemented through four projects dealing with maternal health, family planning, HIV prevention, and adolescent sexual and reproductive health respectively.

Objectives and Scope of the Evaluation

The objectives of the evaluation were i) to assess the relevance, effectiveness, efficiency and sustainability of the approaches adopted by the CP; ii) to provide an independent assessment of the progress towards the expected outputs and outcomes set forth in the results framework; iii) to provide an assessment of how the CO has positioned itself within the development community and national partners; and iv) to provide a set of clear and forward-looking recommendations for the next programming cycle.

The evaluation covers anticipated CP outputs and outcomes within the three UNFPA programmatic areas with an emphasis on the three regions Dushanbe, Khatlon and Soghd where field visits were undertaken. It covers the time period January 2010 to the end of June 2014 and to the extent possible was conducted following the UNFPA CPE Handbook.

Methodology

The CPE was structured around two sets of evaluation criteria: i) relevance, effectiveness, efficiency and sustainability for assessing the programmatic areas; and ii) UN country team coordination and added value for assessing UNFPA's strategic positioning in Tajikistan.

The evaluation was conducted between April and November 2014 in four phases: preparatory phase, design phase, data collection phase, and analysis/reporting phase. It was commissioned and managed by the UNFPA Tajikistan CO. The independent evaluation team consisted of an international team leader based in Switzerland (Ms. Alison King) and two national experts (Ms. Mehriniso Rustamova and Mr. Khiloldin Sobitov). An Evaluation Reference Group provided input into the CPE ToR and comments on the design and draft evaluation reports.

The collection of evaluation data was carried out through document review, stakeholder interviews, group discussions with indirect beneficiaries and direct observation. Over 300 stakeholders and beneficiaries were met; 19 group discussions held. Methodological constraints consisted mainly of security concerns excluding the possibility to travel to the GBAO region and limitations due to lack of proficiency in English on the one hand and Russian/Tajik on the other.

Evaluation Findings

Relevance: The CP addresses important SRH-related rights and needs of women, young people and HIV key populations; it responds to civil society demands for more and better quality social and demographic data for policy-making and decision-taking. At the same time, the CP serves to establish and uphold government priorities and commitments towards these groups. The CP is also firmly anchored in development and human rights agendas and ongoing processes, notably with regard to the MDGs/SDGs, the ICPD, CEDAW and UPR. It is aligned with the objectives of the UNFPA Strategic Plan 2014-2017. While not having determined a unified approach across the CP, the CO has paid high attention to mainstreaming women's and young peoples' concerns. It declared emergency preparedness a priority and took important steps in the areas of SRH and GE to ensure coordination and increase national preparedness.

Effectiveness: UNFPA remains the sole agency supplying contraceptives to the public health system. Since 2010, the number of modern contraceptives has increased from four to eight types. Thanks to the upgraded Contraceptives Logistics Management Information System, around two-thirds of service delivery points are in the position to make available at least three modern methods. In parallel, UNFPA has trained academicians, teaching staff and service providers, including midwives, to apply modern family planning methods. It has taken first steps to introduce a Total Market Approach to contraceptive commodities. Tajikistan is better prepared to respond to the SRH needs of its population in emergencies.

In close collaboration with others, and in the near absence of domestic resources, accomplishments in maternal health have been numerous. They include the introduction of effective perinatal care standards, the reform of the maternity referral system, the establishment of EmOC institutions, the upgrading of midwifery services, the roll out of WHO's Beyond the Numbers approach and the elaboration of a National Plan of Action on Cervical Cancer Prevention. UNFPA is the only organization to provide rapid HIV tests for pregnant women. It has made available ambulances, essential medical equipment and medicines. The Fund has also contributed to bringing the quality of national live birth statistics in line with international standards, but data are not yet fully reliable.

UNFPA has increased the number of young men and women who reject misconceptions about HIV and who are able to identify ways to prevent transmission. In addition, despite difficult circumstances, UNFPA-supported NGOs have played an important role in preventing HIV among thousands of sex workers (SWs) and men who have sex with men (MSM). However, the proportion of young people with correct knowledge of HIV remains low in Tajikistan. Outreach and HIV services are changing the behaviours of SWs and MSM, but not respect for their human rights. SWs and MSM continue to be confronted with stigma and discrimination, making them difficult to reach.

By way of mobilizing other UN agencies, UNFPA has successfully promoted an increased priority on young people in national development policies. Together with UNICEF, the Fund has sensitized and equipped the public health system to address young people's SRH needs. Complementary to community-based youth peer education, Tajik secondary schools are about to introduce healthy lifestyle into their curriculum.

UNFPA can claim credit for a good quality 2010 Population and Housing Census. Moreover, partnering with the Statistical Agency, it has helped modernize population data collection at central and regional levels and lay the foundation for better data analysis and dissemination. UNFPA has also sponsored surveys such as the DHS and promoted population dynamics as part of national policy dialogue. For the first time, a population dynamics chapter was included in the Living Standards Improvement Strategy 2013-2015.

Given the dearth of shelters in Tajikistan, UNFPA's initiative to pioneer victim support rooms (VSRs) in state maternity hospitals for temporary stay of women victims of violence is very welcome. However, the currently eight pilot victim support rooms are under-utilized, as are the two state facilities outside the health sector that UNFPA has supported. This can be ascribed to deeply-engrained cultural norms and insufficient knowledge about the VSRs among women and actors working in the area of women's rights and GBV. Moreover, interviewed health personnel felt insufficiently qualified to approach and refer victims of violence.

UNFPA has also been active on various fronts outside the immediate remit of the health sector. At the policy level, working with others, it has improved official reporting under CEDAW and UPR. It was involved in the formulation of Tajikistan's first domestic violence law, the promotion of an increased minimum legal age of marriage, and the revision of the law on reproductive health. At the level of state institutions, UNFPA facilitated recommendations for improving the gender sensitivity of the justice system; it encouraged the Ombudsman Office to champion women's rights, and involved religious leaders in reducing gender stereotypes and harmful practices. It helped secure a commitment of parliament to screen laws from a gender perspective. UNFPA also successfully collaborated with NGOs and sports federations to transform gender relations.

Efficiency: UNFPA HQ has made RR available to the extent planned and the CO has implemented its initial plan to emphasize RH followed by PD and GE. Only 57% of planned OR have been mobilized, and this mainly thanks to HIV prevention among key populations. Nevertheless, while OR are below target, total annual resources have continually grown since 2011, and the outlook is positive due to the arrival on the scene of new donors and parallel funding.

In terms of programme expenditures, the CO has delivered its support in a timely manner and can boast a very high financial project implementation rate. Interviewed beneficiaries felt that they had received value for money. In line with the corporate emphasis on NEX, the evaluation also reveals a preferred and generally unproblematic use of NEX. On the other hand, according to Atlas project monitoring data, administrative costs for implementing the CP have constantly grown. Over the 2010 to 2013 period they amounted to a third of total expenditures.

Current institutional arrangements for managing the CO have proven challenging because of three management layers (Assistant Representative, Country Director and Representative), including UNDP, geographical distance and competing priorities. CO human and technical resources for implementing the CP are considered appropriate with room for improvement.

Sustainability: UNFPA has built political commitment and institutional capacities and thus created an enabling environment for stakeholders to sustain programme benefits. There are, however, some political risks to its work with HIV key populations. The UNFPA Strategic Plan 2014-2017 is conducive to sustaining and building on the CO's results. It provides room for intensifying investments in young people. Domestic resources for the social sectors remain scarce, rendering ODA and resource mobilization all the more important. The uncertain future of GFATM in Tajikistan is of utmost importance for continuing and sustaining UNFPA's work in HIV prevention. Natural disasters and other emergency settings present a critical threat to UNFPA-supported results. The CO has taken measures to safeguard the durability of CP outputs and outcomes during humanitarian situations.

Strategic positioning: UNFPA has collaborated closely with other development actors; its partners are most often sister UN agencies. CO staff clearly agree that partnerships accelerate progress towards objectives: Benefits mentioned were parallel funding, new funding sources, programmatic synergies and opportunities to expand pilots. The UNDAF and the UNFPA CP are compatible and the CO has seriously pursued coordination with sister UN agencies in all areas of work. It has played a particularly valued role in converging UNCT members around youth and communication. UNFPA has added value to the work of others thanks to generic corporate features such as its mandate to procure contraception, but also thanks to country-specific comparative strengths. Stakeholders particularly appreciated the high personal commitment of UNFPA CO staff.

Monitoring and evaluation: The evaluation reveals that CO staff members spend a significant amount of working time with "their" projects. A relatively simple and practical monitoring system is in place, which staff members dutifully complete. However, a case study has brought to light certain weaknesses in using the CPAP PTT. Apart from in ASRH and HIV prevention, the CO has also produced reasonable evaluative evidence on its performance for learning and planning purposes.

Conclusions

Relevance: Activities implemented under the UNFPA Tajikistan CP 2010-2015 are - and continue to be - very relevant, both at the national and international levels. UNFPA has rightly focused on the health and well-being of women and young people; it is one of very few organizations to speak up and provide for harassed and hushed up SWs and MSM. There is no need to change this focus; rather the need for continuity. There is, however, scope for the next CP to give more consequent emphasis to rural areas of Tajikistan where over two thirds of the population live, where inequities prevail and where most labour migration occurs.

The new CP should include a new and budgeted programmatic area adolescents and youth. It should take a more strategic and results-oriented approach to mainstreaming cross-cutting issues, including emergency preparedness and humanitarian action given the recent identification of Tajikistan as one

of UNFPA's programme countries facing the highest risks of humanitarian crises. Moreover, in line with Tajikistan's classification as an "orange" country - i.e., one that has high needs and a lower to middle ability to finance - the CO should increase its engagement in advocacy and policy dialogue, while continuing to build national capacities and identify ways to reduce direct service delivery.

Effectiveness: Over the past four and a half years, UNFPA has built important national capacities within and outside the health sector that are being put to good use for the benefit of the Tajik population, and particularly women. Results in the area of family planning and maternal health are most impressive given their scale and their contribution to strengthening the Tajik health system where domestic resources are scarce.

The fact that the availability and quality of family planning services have increased over the past years is largely thanks to UNFPA. Nevertheless, international and national statistics continue to expose low contraceptive prevalence and an unmet demand for contraception. More efforts are required to increase demand for and supply of modern contraceptives and improve the quality of gender-sensitive and youth-friendly services. Recent steps to engage other development actors are very welcome, as is UNFPA's initiative to facilitate a Total Market Approach for family planning.

UNFPA has helped to considerably increase the availability and quality of maternal health services, including EmOC. Although the present evaluation did not assess impact, it seems safe to conclude that UNFPA has thus contributed to reducing maternal mortality, albeit one that remains high irrespective of which data are consulted. UNFPA should pursue efforts to increase national capacities to deliver comprehensive maternal health services while using the new CP to bring around a better involvement of rural maternity houses. It should facilitate a better understanding of the necessity to and ways to integrate family medicine in antenatal care; scale up efforts to prevent cervical cancer; ensure availability of drugs; and help strengthen the statistical capacities of the public health sector.

UNFPA work in the area of HIV prevention among young people as well as SWs and MSM can be considered effective. As one of only few organizations active in a politically-sensitive area, and in view of the concentrated stage in which the epidemic is, UNFPA should continue its efforts to prevent HIV among SWs and MSM, including through mainstreaming. From a human rights and public health point of view, it should expand its interventions to include efforts to reduce stigma and discrimination. Since the situation and needs of young people differ considerably from those of SWs and MSM, the evaluation team sees merit in designing two different projects under the next CP.

The ASRH project has been effective. It has contributed to putting ASRH on the national development agenda, especially in the health and education sectors. However, young people's awareness of SRH remains low and young women are far less likely to use condoms and other methods of contraception than older women. The adolescent fertility rate is worryingly high; the number of registered abortions has increased. The future adolescents and youth programmatic area should go beyond the health care system and into other relevant sectors whose contributions can improve SRH and the reproductive rights of young people. It should build on assets and results achieved under the current HIV prevention and ASRH projects and be designed with the active involvement of young people as agents of change.

UNFPA work in the area of population and development has been effective. While a basis has been laid, the evaluation found weaknesses within the Statistical Agency at district level as compared to central and regional levels. Evidence also points to unsatisfied needs of national specialists for more and better data and in-depth analysis, in particular on SRH-related topics - e.g., as regards VAW, HIV key populations, early marriages, unmet contraception coverage and live births.

The GE programme has made a difference, although not quite reaching its potential in terms of strengthening the health sector's response to VAW. Although currently only partially fulfilling their purpose, VSRs call for further investments in view of implementing the new law and national programme on domestic violence and fulfilling CEDAW commitments. In the short-term, UNFPA and the MoHSP should focus on applying the new VSR regulation, informing other actors and potential clients about their existence and the types of services offered, embedding the VSRs in GBV reference

systems, and ensuring reliable data management. VSRs cannot function in isolation. When ultimately rolling them out, locations where complementary services exist or where there is potential for creating them should be prioritized. UNFPA and the MoHSP should also consider complementary ways to increase the health system's response to VAW - e.g., by institutionalizing pre- and in-service GBV sensitization and screening trainings.

Outside the health sector, UNFPA has achieved important accomplishments in GE, a prerequisite for successful RH interventions. It is commended for having pursued a balanced approach to engaging governmental and non-governmental stakeholders. Nevertheless, there are "loose ends" and deplorable statistics that deserve and require considerable efforts. Given limited resources and to avoid fragmentation, the future programmatic area should scale down investments in non-health partners and arenas based on its comparative advantage, continued needs and an assessment of likely impact on UNFPA's overall goal - i.e., the achievement of universal access to sexual and reproductive health, the realization of reproductive rights, and the reduction in maternal mortality.

Efficiency: The CO's performance as regards OR mobilization has been unsatisfactory. Arguably, the CO has also reported considerable parallel funding, which is another way of supporting UNFPA's causes. In fact, this modality might become more and more important in future - as an alternative to OR - given the complexity of development interventions, donor preference to preserve identities and demonstrate results, and the quest for administrative efficiency. The question thus arises how to define, plan and account for parallel funding in CPs as part of results-oriented budgeting.

The level of costs to administer the CP in relation to total expenditures is of concern. While there is no known ceiling for administrative costs and the evaluation team is unable to make comparisons with other UNFPA Cos, it would seem that they are on the high side, and that steps to assess potential cost savings should be taken.

The concerns related to the shared leadership of the CO are justified, although any weaknesses in the set-up momentarily and fortunately do not seem to have had any significant implications thanks also to the persons involved. However, in terms of risk management, and possibly also for the benefit of other COs, UNFPA would be well advised to review the duties and responsibilities of and relationships between ARs, CDs and UNFPA Representatives where jointly responsible for a particular UNFPA CO, as well as to consider updating the MoU with UNDP. As for any modifications to human and technical resources for implementing the CP, structure should follow the substance of the next CP. This said, given its suggested greater profile, the CO should be prepared to increase capacities to manage the new adolescents and youth programmatic area.

Sustainability: The CO has built important partnerships with a row of executive and legislative state branches within and outside the health sector. This has helped - to differing extents - to build ownership and thus to make continuation of benefits more likely. Nevertheless, the evaluation team suggests that partnerships and Implementing Partners be reviewed in the context of planning the next CP. As regards financial risks, the Government of RT cannot be expected to step in on a large scale with domestic resources. Resource mobilization therefore remains all the more important for maintaining and leveraging UNFPA-supported results. Generally speaking, the outlook is positive given the substantial increase in ODA over the recent past years. The project to prevent HIV among SWs and MSM faces considerable political and financial risks, which should be urgently addressed and a solution found.

Strategic positioning: UNFPA in Tajikistan is well positioned in view of its ability to respond to national needs while adding value to country development results. Its contribution to UN system coherence is very valuable, despite its relatively small presence. This situation is an ideal starting point for developing a next CP that is embedded in and contributes to the new UNDAF 2016-2020 and that continues to build on partnerships and comparative advantages. Starting the strategic planning process of the 4th CP and ensuring an intensive participation in the ongoing UNDAF preparation process seem imperative to ensure an optimal point of departure for the next CP.

Monitoring and evaluation: Monitoring and evaluation are related and complementary functions, intended to provide pertinent information for decision takers. The evaluation team concludes that the UNFPA Tajikistan CO has taken performance monitoring very seriously, but that deficiencies in implementation need to be tackled in order for it to be dependable, both at country and corporate levels. Evaluative work ought to be better planned to ensure better coverage.

Recommendations

Recommendations largely relate to the design of the 4th CP 2016-2020. Strategic recommendations, related to the CP as a whole, are listed below. They are supplemented in the main body of the report by recommendations for each outcome area (part 7).

A. Country Programme Design

A1: UNFPA CO and MEDT to elaborate as soon as possible road map for developing the 4th UNFPA CP for Tajikistan in a consultative manner.

A2: UNFPA CO to ensure continued senior-level involvement in UNDAF preparation process with regular consultation of CO technical staff.

A3: UNFPA CO to construct the 4th CP around four programmatic areas concurring with the SP 2014-2017 strategic outcomes: SRH (including maternal health, family planning and HIV); youth & adolescents; GE & women's empowerment; and population dynamics. This implies a higher profile for UNFPA's work with and for young people than thus far.

A4: Based on recent and ongoing inter-governmental processes, UNFPA CO to use the SDGs, the UPR and CEDAW as overarching international reference frameworks for the 4th CP, besides the ICPD agenda.

A5: In line with Tajikistan's inclusion in the group of countries at particular risk of emergencies, UNFPA CO to plan for an increased preparedness for and engagement in humanitarian settings in all programmatic areas.

A6: UNFPA CO to demonstrate in the 4th CP how it aims to reduce inequities in gender relations and access to SRH services in rural areas of the country.

A7: In terms of strategic interventions, while continuing to build national capacities, UNFPA CO to increase investments in advocacy and policy dialogue, and (continue to) identify ways to reduce service delivery.

B. Programme Management and Implementation

B1: UNFPA CO to review administrative costs accruing to HQ and the CO for managing the Tajikistan CP and devise ways for future cost savings.

B2: UNFPA CO to strategize on future partners for funding and implementing the 4th CP and especially the project to prevent HIV among SWs and MSM given the political and financial risks.

B3: UNFPA CO to review current CO organigram and staffing in connection with 4th CP and revised business plan.

B4: Given its increasing significance, UNFPA HQ to provide guidance to COs on how to define, plan and account for parallel funding in support of UNFPA CPs as part of results-oriented budgeting.

B5: UNFPA HQ to clarify division of labour between ARs, CDs and UNFPA Representatives where they are jointly responsible for leading a UNFPA CO.

B6: UNFPA HQ to consider the necessity and desirability of updating the MoU between UNFPA and UNDP on UNFPA representation at country level.

C. Programme Monitoring and Steering

C1: UNFPA CO/RO to develop guidelines for using the CPAP PTT, including on its links to AWPs and SPRs, and intensify on-the-job support and quality assurance.

C2: UNFPA CO/RO to develop a work plan to ensure a regular, systematic and coordinated programme of decentralized evaluations during the 4th CP covering all programmatic areas.

PART 1: INTRODUCTION

This part of the evaluation report provides basic information for the reader to understand the Tajikistan country programme evaluation (CPE). The following sections focus on the purpose and objectives of the CPE, the scope of the CPE and the applied methodology.

1.1 Purpose and Objectives of the Country Programme Evaluation

In April 2014, the UNFPA Tajikistan country office (CO) commissioned an external evaluation of its Tajikistan country programme (CP) 2010-2015 as per the 2013 UNFPA Evaluation Policy. The purpose of the country programme evaluation (CPE) is twofold: evaluation results are intended to ensure accountability of UNFPA for relevance and performance; they are meant to facilitate institutional learning and evidence-based programming of the 4th UNFPA CP 2016-2020 support to the Government of the Republic of Tajikistan (RT). The intended users of the evaluation are decision-makers within UNFPA (country office, regional office and headquarter divisions), the UNFPA Executive Board, government counterparts in the country, donors and other partners. The objectives of the CPE are:

(i) To assess the relevance, effectiveness, efficiency and sustainability of the approaches adopted by the CP;
(ii) To provide an independent assessment of the progress of the CP towards the expected outputs and outcomes set forth in the results framework;
(iii) To provide an assessment of how the CO has positioned itself within the development community and national partners, in view of its ability to respond to evolving national needs while adding value to country development results; and
(iv) To provide a set of clear and forward-looking recommendations for the next programming cycle.

1.2 Scope of the Country Programme Evaluation

The subject of the evaluation is the UNFPA Tajikistan CP 2010-2015. The evaluation covers anticipated CP outputs and outcomes within the UNFPA programmatic areas population and development (PD), reproductive health and rights (RH) and gender equality (GE), with an emphasis on the three oblasts (regions) Dushanbe, Khatlon and Soghd (see *sampling* below). It covers the time period January 2010 to the end of June 2014.

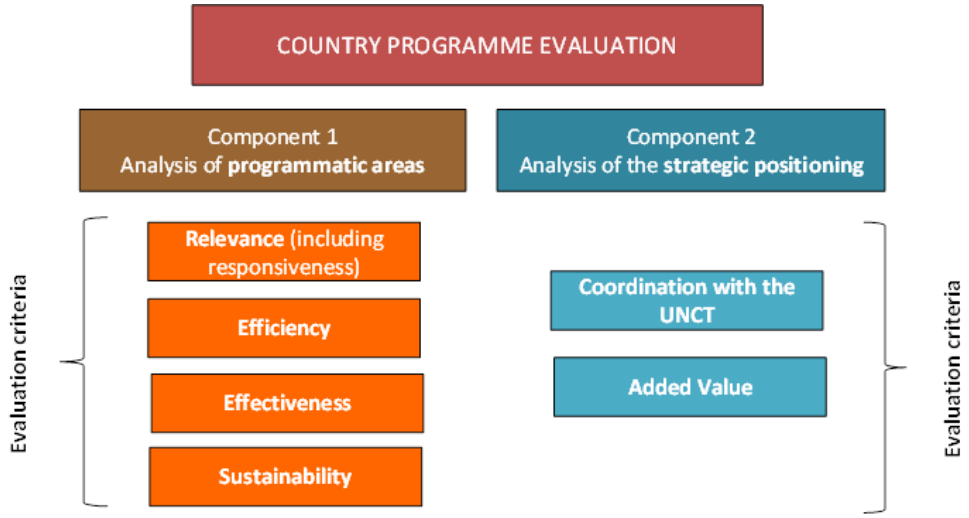
Because the gender equality programmatic area was already evaluated by the Tajik Centre of Sociological Research "Zerkalo" in 2011, the present evaluation emphasizes performance since 2012. Moreover, not having visited the Rasht valley, it does not attempt to assess UNFPA's contribution to the UN Joint Programme Empowering Communities with Better Livelihoods and Social Protection in the Rasht Region.

1.3 Methodology and Process

Evaluation components, criteria and questions

As per the UNFPA CPE Handbook, the CPE has two separate components: (i) analysis of the CP programmatic areas; and (ii) analysis of UNFPA's strategic positioning. The Handbook clearly defines a set of six compulsory evaluation criteria for both components (figure 1). Evaluation teams are free to incorporate additional criteria. This was not the case for Tajikistan.

Figure 1: Evaluation Criteria in a UNFPA CPE



Source: UNFPA CPE Handbook

While evaluation criteria encompass a wide range of aspects and features, evaluation questions are used to focus the evaluation on specific aspects, enabling the evaluation team to focus the evaluation work on a limited number of key points. Establishing a set of evaluation questions allows for a more targeted data collection process, a more concentrated and in-depth analysis and eventually, a more focused and useful evaluation report. The UNFPA CPE Handbook recommends selecting eight to ten evaluation questions.

During the preparatory phase, UNFPA selected and adapted evaluation questions to be covered by the CPE from a standard list of evaluation questions for CPEs and included them in the CPE Tajikistan ToR (annex 1). During the design mission, the evaluation team adjusted the pre-selected evaluation questions in consultation with the UNFPA CO, the UNFPA RO M&E Adviser and the Evaluation Reference Group (ERG) (table 1).

Table 1: CPE Tajikistan Evaluation Questions

Component 1: Analysis of programmatic areas
Relevance
EQ1: To what extent is the UNFPA country programme consistent with government priorities and beneficiaries' needs? EQ2: To what extent is the UNFPA country programme consistent with UNFPA Strategic Plans, the ICPD Programme of Action and the MDGs?
Effectiveness
EQ3: To what extent have the UNFPA country programme's intended outputs been produced and contributed to the achievement of UNFPA country programme outcomes? EQ4: To what extent has the UNFPA country office successfully used partnerships with other development partners to achieve its objectives? EQ5: To what extent have UNFPA country office monitoring and evaluation mechanisms helped steer the country programme?
Efficiency
EQ6: To what extent has the UNFPA country office made good use of its financial and human resources to implement the country programme?
Sustainability
EQ7: To what extent has the country office identified and addressed factors and conditions affecting the

sustainability of UNFPA-supported results?
Component 2: Analysis of strategic positioning
UN country team coordination
EQ8: To what extent has UNFPA contributed to the functioning and consolidation of UN country team coordination mechanisms?
Added value
EQ9: What is the main added value of UNFPA's interventions in Tajikistan as perceived by national counterparts and other development actors?

An evaluation matrix was prepared as a central tool for the design and conduct of the CPE (annex 2). 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 process and management arrangements

The evaluation was conducted between April and November 2014. The evaluation process was divided into four phases - i.e., preparatory phase, design phase (including one-week design mission[7]), data collection phase (including three-week field mission[8]), and analysis/reporting phase.

The evaluation was managed by Ms. Aziza Hamidova, UNFPA Assistant Representative heading the UNFPA Tajikistan CO and Mr. Alisher Ashurov, NPO on PD and CO M&E Focal Point. The independent evaluation team consisted of three persons, one international team leader based in Switzerland (Ms. Alison King) and two national experts (Ms. Mehriniso Rustamova and Mr. Khiloldin Sobitov). During the design and field mission, they were supported by an interpreter (Mr. Dilshod Nadyrov); during the report drafting phase by a voluntary translator (Mr. Shukurov Ikromjon). Each evaluator was contracted for 60 days. An Evaluation Reference Group (ERG) provided input into the CPE ToR and comments on the design and draft evaluation reports.

Data collection

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

- Review of documents (annex 3), websites and financial data;
- Semi-structured and informal stakeholder, training and study tour follow-up interviews[9] (annex 4);
- Group discussions (annex 5) with indirect - i.e., community-level - beneficiaries for whom the services are intended; and
- Direct observation of UNFPA-targeted institutions and areas, during which photographs were taken and have been included in this report.

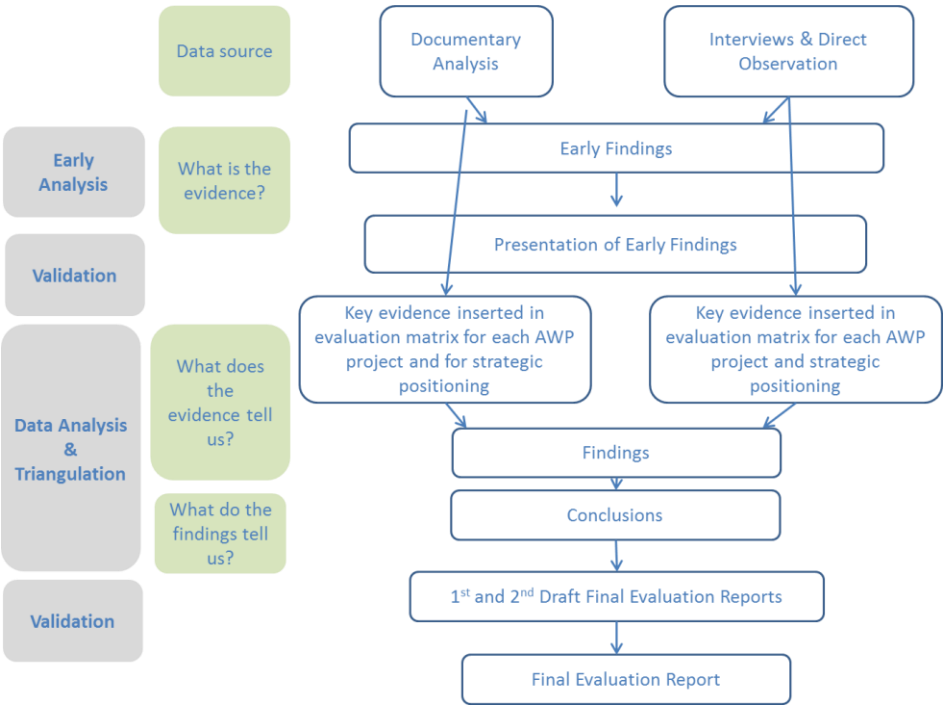
The UNFPA CPE Handbook recognizes that a three-week field mission does not permit the collection of representative data: "The evaluators should not aim at obtaining a statistically representative sample, but rather an illustrative sample". This is particularly pertinent in the case of training follow-up (see *sampling* below). Since 2010, UNFPA has trained thousands of persons all over the country in all areas of its work. Even if randomly identified for interviews, information collected from individual beneficiaries may by no means be extrapolated to the general population.

Data analysis

[7] See design report dated 28 June 2014.
[8] See debriefing presentation of 4 July 2014.
[9] Face-to-face and by telephone.

The evaluation matrix with its evaluation criteria, questions and indicators provided the overall analytical framework against which data were analysed by way of triangulating information obtained through interviews, document analysis and direct observation (figure 2). According to the UNFPA CPE Handbook, evaluators are expected to conduct retrospective assessments for the most part - i.e., analyse what has happened and the reasons why. Prospective assessments are an option, but should be explicitly indicated and explained in the evaluation report.

Figure 2: Data Analysis and Triangulation



Source: Evaluation team

Sampling

Considering the country context and bearing in mind expected CP outputs and outcomes, three oblasts (regions) of Tajikistan were chosen for data collection - i.e., Dushanbe, Kurgantube Zone and Kulyab Zone in Khatlon, and Soghd. They were chosen on the basis of below criteria, which correspond in large part to those suggested in the UNFPA CPE Handbook:

- Existence of beneficiaries targeted by all UNFPA programme components;
- Volume of UNFPA assistance in terms of funding and capacity building;
- Coverage of activities implemented by direct execution (DEX) and national execution (NEX) modalities;
- 2012 Demographic and Health Survey (DHS) survey indicators related to maternal health (MH), adolescent sexual and reproductive health (ASRH) and gender[10];
- Country data on socio-economic conditions and human rights; and
- Current political conditions[11].

The CPE field mission schedule was as follows:

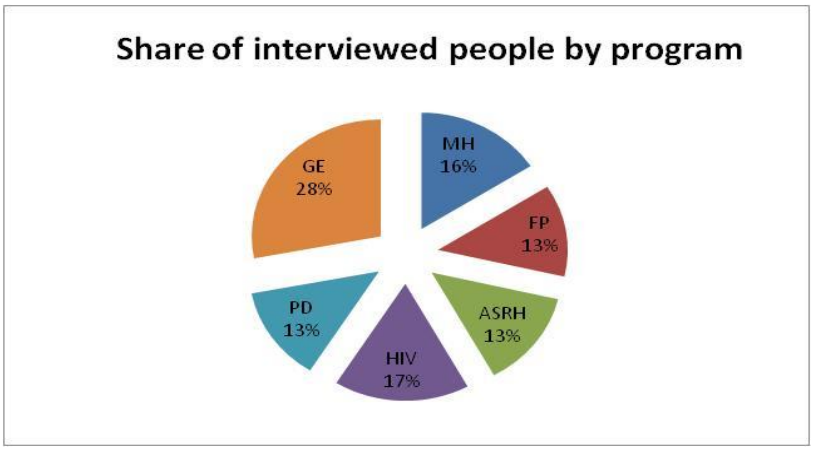
- 16 to 20 June: Khatlon oblast (Kurgan-Tube and Kulyab zones)
- 23 to 27 June: Soghd oblast

[10] Maternal mortality ratio (MMR), HIV prevalence and gender-based violence.
[11] At the initial stage, the GBAO region was included in this list, but due to unrest excluded later on.

- 20 June to 4 July: Dushanbe

Using the stakeholder mapping provided by the UNFPA CO and supplemented by the evaluation team, a non-random selection was made of stakeholders in the three oblasts, with an attempt to achieve an appropriate picture of work in each UNFPA programmatic area and project. During the field mission, additional stakeholders were identified and contacted. Overall, the evaluation team met over 300 stakeholders and beneficiaries, of which 42% men and 58% women; because of unavailability, 23 interviews were cancelled. Government officials represented the largest stakeholder group (58%), followed by international and national NGOs (32%), UN organizations (9%) and bilateral donor agencies (1%). Most interviews were conducted in Dushanbe (148) followed by Khatlon oblast (102) and Soghd oblast (64). Figure 3 depicts the share of interviewees per project.

Figure 3: Share of Interviewed Persons by Project



Source: Evaluation team

4,758 persons were trained by UNFPA and its Implementing Partners (IPs) between 2010 and 2013.[12] The evaluation team applied a combination of purposive and random sampling of training beneficiaries to determine training follow-up interviews, with a particular focus on 2012 and 2013.[13] The target sample size was a total of approximately 80 interviews. Priority was given to short telephone interviews. Due to unavailability as well as time and language constraints, the evaluation team managed to conduct 72 training follow-up interviews.

Since 2010, UNFPA has enabled 48 persons[14] to participate in study tours and exchange programmes organized outside the country. The evaluation team had planned to approach up to 17 beneficiaries, including both male and female beneficiaries, for interviews. It ultimately conducted 16 study tour follow-up interviews.

Indirect beneficiaries - i.e., service users, were also approached to identify their satisfaction with quality and quantity of received services. The evaluation team conducted 19 group discussions with indirect beneficiaries (annex 5).

Evaluation ethics

All requirements relating to the independence, the prevention of conflicts of interest and respect for stakeholders' dignity and self-worth defined by the UNEG Ethical Code of Conduct, Ethical Guidelines as well as Standards for Evaluation in the UN System were duly observed.[15] Interviewees and group discussion participants such as men who have sex with men (MSM) and female sex workers (SWs)

[12] At the time of the design mission, information for 2014 was not available.
[13] A total of 1,375 training participants.
[14] CPAP Monitoring List 2010-2013.
[15] http://www.unevaluation.org/document/detail/100; http://www.unevaluation.org/document/detail/102; http://www.unevaluation.org/document/detail/22;

and victims of violence were assured confidentiality of their responses and informed about their right not to engage. To reduce bias, and to the extent possible, meetings were attended by more than one evaluator.

Evaluation limitations

As mentioned above, the evaluation team had to exclude the possibility of traveling to the GBAO region due to unrest. Furthermore, the quality and timeliness of the evaluation process was affected by a lack of English proficiency on the part of one national expert. Similarly, the international team leader was unable to grasp details and nuances included in locally-produced documents and websites due to them being in Russian/Tajik. She was unable to conduct telephone interviews. This language limitation was to a large extent mitigated by the assistance of an interpreter and a translator. Apart from this, the team did not encounter any material restrictions to the quality of the evaluation. It is of the view that the evaluation is based on a balanced set of information and data gathered from a diverse stakeholders and beneficiaries.

1.4 Report Outline

This evaluation report is divided into seven parts. Part 1 introduces the Tajikistan country programme evaluation. Part 2 provides background information about the context in which UNFPA works in Tajikistan. Part 3 acquaints the reader with the 3rd UNFPA CP 2010-2015, its programmatic response and the financial resources at the disposal of the CO. Part 4 assesses the performance of the CP four-and-a-half years into its implementation against the evaluation criteria and associated evaluation questions. Part 5 considers the design and implementation of the CO monitoring and evaluation system. Parts 6 and 7 present the evaluation team's conclusions and recommendations for action.

PART 2: COUNTRY CONTEXT

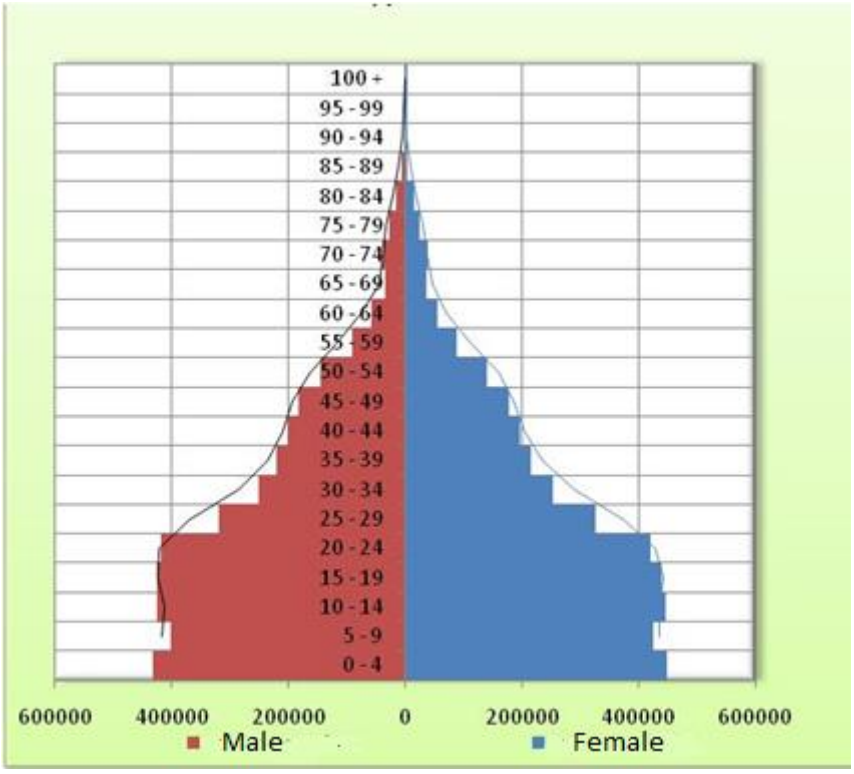
This part of the evaluation report provides background information for the reader to understand the country context in which UNFPA works in Tajikistan.

2.1 Development Challenges and National Strategies

A small, mountainous and landlocked country, with a population of around 8.16m, Tajikistan is vulnerable to a range of stresses and climate-related disasters such as floods and landslides caused by intense rainfalls and rapidly melting snow. It is also still recovering from a civil war that lasted from 1991 to 1997 following the collapse of the Soviet Union. Tajikistan is a multi-ethnic country, where, according to the 2010 Population and Housing Census, people of more than one hundred ethnic groups live. Tajiks constitute more than 85% of the population. Other major ethnic groups are the Uzbek, Kyrgyz, Russian and Turkmen. The official state language is Tajik; Russian is widely spoken as the language of inter-ethnic communication.

Tajikistan's population is predominantly young. 58% of the population is under age 25; 38% is younger than 15. The population pyramid in figure 4 depicts the age structure by both sexes for the year 2014. Typical of populations that have experienced high fertility, the pyramid has a wide base. For the last three decades, however, population growth has considerably slowed, from almost 3.5% in the 1980s to 2.1% in 2010.

Figure 4: Tajikistan Age Structure



Source: Tajikistan in Figures 2014

Tajikistan's Human Development Index (HDI) value for 2013 is 0.607, positioning the country at 133 out of 187 countries, below the average of 0.614 for countries in the medium human development group and of 0.738 for countries in Europe and Central Asia. In 2013, Tajikistan had a Gender Inequality Index (GII) value of 0.383, ranking it 75th of 152 countries; it came 102nd (of 142 countries) in the 2014 Global Gender Gap Index, occupying together with Armenia and Turkey the final positions in the Central Asia and Europe region.

Progress towards the MDGs has been uneven. Tajikistan is a low income country. It is the poorest country emerging from the former Soviet Union: In 2011, Tajikistan's GDP per capita (PPP) was $2,300. For the last three years, economic growth was 6.5 to 7.4 and 7.5% respectively[16], attributed to higher growth in retail trade, services and agriculture and remittances. The poverty rate is on a sustainable downward trend. It decreased from 50% in 2008 to 46.7% in 2009, 45% in 2010, 41% in 2011 and 38.3% in 2012. Enrolment in primary education (MDG 2) is quasi universal primary education, although there are wide variations between regions. Gender equality and women's empowerment (MDG 3) is possible to achieve if some changes are made. 98% of women aged 15-49 are literate compared to 96% of men.[17] 2012 DHS data showed that women had completed about nine years of education. More than 90% had attended at least some secondary school. However, the number of girls dropping out of secondary schools remains sizeable and early marriage is still common. Only 6% of the female population has attended higher education.[18] MDG 6 on HIV/AIDS, malaria and other contagious diseases could also be achieved. On the other hand, MDG 4 to reduce child mortality and MDG 5 to improve maternal health are off track although both are declining.

Despite gradual economic growth, a high level of unemployment remains one of the basic social and economic problems in Tajikistan. While the official unemployment rate of 2.5% is not high, real unemployment is considered much higher, particularly among young people. In search of working opportunities and higher incomes, approximately 33% of the economically-active population (mostly men) work abroad, mostly in Russia and Kazakhstan.[19] This has positive - better education and health care services for family members - and negative - leakage of intellectual capabilities and distorted family situations - effects on the country. Remittances were equivalent to 47% of GDP in 2012.[20]

Reproductive health

The Government of RT is committed to improving equity of access to essential health care services. There are a number of strategies, legislation and standards/protocols for promoting health in Tajikistan (box 1). However, despite positive trends, limited health financing[21], outdated medical equipment and technologies, poor conditions of buildings and facilities, shortage and high turnover of health care workers, and limited access to health care services and drugs are still a problem.

Box 1: National Strategies, Legislation and Standards/Protocols on Reproductive Health

- National Health Strategy (NHS) of the Population of the Republic of Tajikistan 2010-2020
- Living Standards Improvement Strategy for 2013-2015
- Law on Reproductive Health and Reproductive Rights 2002
- Law on Prevention and Combating HIV/AIDS 2014
- National Strategic Plan on Reproductive Health 2005-2014
- National Plan of Action on Safe Motherhood 2008-2014
- Strategy on Health Information Management System 2010
- National Standards on Managing Complications in Pregnancy and Childbirth and on Bleeding, Eclampsia, 2010-2014
- Regulation on Restructuring of the Maternal and Child Health Services and Establishment of Referral System 2008-2014
- Regulation on Improvement of Antenatal Care Services and HIV Testing of Pregnant Women 2008-2013
- Program on Ensuring Access to Safe Abortion and Quality Post-abortion Care by 2015

[16] http://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG/countries/TJ-7E?display=default.
[17] Statistical Agency.
[18] 2012 Tajikistan Demographic and Health Survey (DHS). According to the 2014 Gender Gap Report, Tajikistan is the lowest performing country in the Central Asia and Europe region on secondary and tertiary education indicators.
[19] Statistical Agency.
[20] http://www.worldbank.org/en/country/tajikistan/overview.
[21] Over the last 15 years, the proportion of expenditures for health services of GDP has constantly declined from 4.5% (1991) to 1.3% (2006), from where it increased to - albeit a still low - 1.7% in 2013.

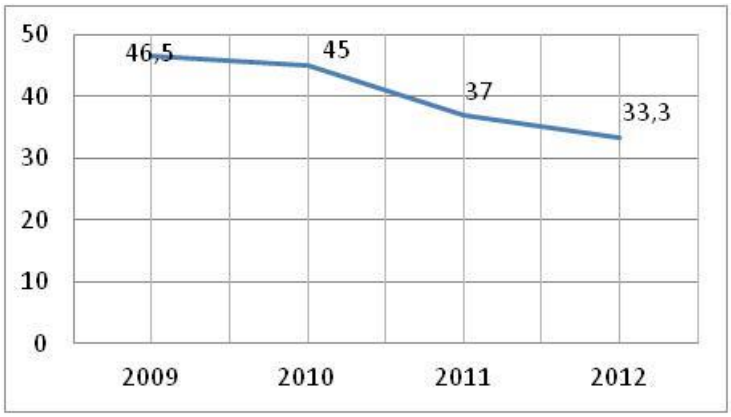
- The Concept of State Demographic Policy of the Republic of Tajikistan for 2003-2015
- National Youth Health Development Strategy 2011-2013
- National Youth Policy till 2020
- Programme on the Response to the Epidemic of HIV in the Republic of Tajikistan for the Period 2011-2015
- National Strategy for Health Care of Children and Adolescents until 2010-2015
- National Programme on Healthy Life Style Education

Source: Evaluation team

In 2014, the MoHSP will report on the two National Plans on RH and Safe Motherhood, including accomplishments and remaining gaps, and will make recommendations for action. It is then planned to develop a joint National Action Plan on RH combining FP, MH, ASRH and HIV with gender-sensitive approaches. Lessons learnt regarding financial allocations and monitoring and evaluation will be an important section in the new plan.

Tajikistan has a comparatively high level of maternal mortality. According to MoH[22] data, the maternal mortality ratio (MMR) was 33.3 per 100,000 live births in 2012 (down from 46.5 in 2009); the 2005 MICS estimated an MMR of 97 deaths per 100,000 live births. WHO, in turn, estimated a MMR of 65 per 100,000 in 2010. The Government of RT recognizes that official indicators are unreliable due to outdated definitions and data collection methods, underreporting and incomplete registration of vital statistics. However, it should be noted that the MMR is decreasing, albeit short of the reduction by three quarters needed to meet MDG 5. Figure 5 depicts trends for 2009-2012.

Figure 5: Maternal Mortality Ratio 2009-2012



Source: MoH

To further reduce the MMR, the MoH with support from UNFPA has been reorganizing maternal and child health (MCH) services, institutionalizing emergency obstetrics care (EmOC) and implementing evidence-based strategies, including effective perinatal care (EPC) and the WHO Beyond the Numbers initiative. The Preventing Mother to Child Transmission (PMTCT) programme has been integrated with antenatal care services at the primary health care (PHC) level and rapid HIV tests have been introduced for pregnant women.

Tajikistan has no government funding for contraception. While there has been some ad hoc support from other organizations - e.g., IPPF - UNFPA remains the sole supplier for the public sector. In 2005, with the assistance of UNPFA, a Contraceptives Logistic Management Information System (CLMIS) for contraceptives was rolled out nationally. With UNFPA's support, it has been continuously upgraded with computer software, warehouses and vehicles. Tajikistan has experienced a significant decline in fertility, from a high 6.3 at the beginning of the 1990s to the current 3.2. However, according to the DHS and national medical statistics, total use of contraceptives was only 28% in 2012. This is a substantial decline when compared with 2005 MICS contraception prevalence data

[22] The MoH was renamed to Ministry of Health and Social Protection (MoHSP) as of 1 January 2014. The present evaluation report uses MoH unless explicitly talking about 2014 and beyond.

(37%). At the time of the field mission, UNFPA, together with USAID, was undertaking an additional qualitative survey in an attempt to validate data and better understand trends related to unmet needs for family planning. Some interviewees suggested that the use of modern contraception methods has a seasonal feature, linked to labour migration.

According to the UNAIDS Report on the Global AIDS Epidemic 2012[23], Tajikistan is among those countries where HIV prevalence has increased by more than 25% over the last ten years. Nevertheless, the epidemic remains in a concentrated stage, affecting less than one per cent of the general population, but spreading among key populations of men having sex with men (MSM), sex workers (SWs) and people who inject drugs (PWID). Labour migrants and young people are also vulnerable. According to Republican Aids Centre (RAC) data from 1991 to 1 July 2013, there were 5,144 cases of HIV-registered persons in Tajikistan, out of which 3,774 men. The rate of newly-diagnosed infections in 2013 was 15 per 100,000 people. More than 90% of people living with HIV face various forms of discrimination, especially in communication (90%), employment (67%), medical care (67%), when applying to law enforcement agencies (34%) and violence (39%). Women (95%) tend to experience more discrimination than men.[24] Of the reported cases with information about transmission mode in July 2013, 37.2% were infected through heterosexual contact, 55.3% through injecting drug use, and 2.3% through mother-to-child transmission.[25] Policies, programmes and projects to address the epidemic exist. The major part of the Programme on the Response to the Epidemic of HIV 2011-2015 is covered by international donors and particularly the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

Young people face significant challenges in areas such as quality social services and education and health, in particular reproductive health. Early marriage, incomplete knowledge about family planning and spread of HIV and sexually-transmitted diseases (STIs) are prevalent. One third of registered HIV cases are among 15-24 year old people. Youth are therefore one of the three target groups of the National Strategic Plan for the Prevention of HIV/AIDS. According to MICS (2005), young people's awareness of sexual and reproductive health remained low. Young women were far less likely to use contraception than older women - i.e., 9% of women age 15-19. According to the UNICEF, only 27% of teenagers knew about the correct and/or consistent condom use. The registered number of abortions among young women accounted for 9% of total cases.[26]

Population and development

Access to reliable and internationally comparable data and its use is essential for policy making that responds to national development priorities and needs. The Government of RT is open to collecting, analysing and disseminating population data and has made significant efforts to improve data reliability. The State Population Development Policy (2003-2015) was approved by Parliament and reflects not only demographic issues, but also population and development comprehensive issues, including population composition (children, adolescents, elderly, disabled and family development), population health, education, social welfare housing, food security, environment and integration of population factors into development planning. Over the last ten years, population surveys and censuses have been conducted regularly (table 2) and the amount of available data has grown.

Table 2: List of Surveys and Studies related to PD in Tajikistan

1999	Tajikistan Living Standards Measurement Study (TLSS)
2000	Population Census
2000	Multiple Indicator Cluster Survey (MICS)

[23] Mid-term Review of the National HIV/AIDS Programme, October 2013.
[24] National Research on Identifiable Forms of Stigma and Discrimination against People Living with HIV, 2010.
[25] RAC, 2013, http://nc-aids.tj/statistika.html accessed 6 June 2014.
[26] UNICEF: Development of Youth-Friendly Services in Tajikistan, 2007.

2002	Demographic Survey (Direct estimates)
2002	Demographic Survey (Indirect estimates)
2003	Tajikistan Living Standards Measurement Study (TLSS)
2005	Multiple Indicator Cluster Survey (MICS)
2007	Tajikistan Living Standards Measurement Study (TLSS)
2010	Population and Housing Census
2012	Demographic and Health Survey (DHS)

Source: Evaluation team

Although the national statistical office, the Statistical Agency, collects data on many PD aspects and population dynamics, they often differ from those published by international agencies in terms of format and accessibility. The expectation is for future data to be more accessible to a wide range of users and for users to be able to perform statistical and other forms of analyses. Another important aspect is to improve the civil registration system to meet international standards and requirements.

Gender equality

The Constitution of RT and the 2005 Tajik Gender Equality Law[27] guarantee the same rights of men and women. Tajikistan has signed a range of international goals and conventions that mandate GE, including the MDGs, the ICPD PoA, the Beijing Declaration and Platform for Action, and the Convention on the Elimination of Discrimination against Women (CEDAW).[28] In April 2014, Tajikistan was elected member of the Commission on the Status of Women (CSW) until 2018. In July 2014, it ratified the Optional Protocol to CEDAW.[29] Also in 2014, it submitted its Beijing+20 National Review Report.[30] National laws, policies and strategies in the area of GE are well established (box 2). Since the beginning of the 3rd UNFPA CP, several laws and decisions have been adopted aimed at eliminating discrimination against women. The National Development Strategy (NDS) 2010-2015 has a dedicated chapter on the promotion of GE. In May 2010, the Government of RT approved the National Strategy to Promote the Role of Women in Tajikistan for the Period 2011-2020. In June 2010, the Tajikistan Family Code was amended to change legal marriage age from 17 to 18 years of age. In March 2013, the Parliament passed the Law on the Prevention of Violence in the Family. In early 2014, a National Programme on the Prevention of Violence for 2014-2023 was approved.

Box 2: Key National Laws, Policies and Strategies on Gender Equality

- Constitution of the Republic of Tajikistan
- National Development Strategy, 2010-2015
- Guidelines for a State Policy to Ensure Equal Rights and Opportunities for Men and Women in the Republic of Tajikistan for the Period 2001-2010
- Tajikistan Family Code, 1998
- Strategic Plan of the Republic of Tajikistan on Reproductive Health of the Population for the Period till 2014, 2004
- Tajik Gender Equality Law, 2005
- Law on the Establishment of the Human Rights Ombudsman/Commissioner for Human Rights, 2008
- Strategy of the Commissioner for Human Rights for the Period 2011-2015
- Law of on Reproductive Health and Reproductive Rights, 2011

[27] Law of the Republic of Tajikistan on State Guarantees of Equal Rights for Men and Women and Equal Opportunities in the Exercise of Such Rights, 1 March 2005.
[28] CEDAW was ratified on 26 June 1993. In August 2011, Tajikistan submitted its combined 4th and 5th periodic reports. The 6th periodic report is due in October 2017.
[29] http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/Countries.aspx?CountryCode=TJK&Lang=EN.
[30] http://www.unescapsdd.org/files/documents/Beijing20_national_review_Tajikistan.pdf.

- National Strategy to Promote the Role of Women in Tajikistan for the Period 2011-2020 and Action Plan
- Law on the Prevention of Domestic Violence, 2013
- National Programme on the Prevention of Violence for 2014-2023

Source: Evaluation team

However, implementation of laws and programmes remains a challenge and gender-related issues are present in all aspects of the social and economic life of the country. Women in Tajikistan still disproportionately suffer from poverty, traditional patriarchal society and a weak system to protect their fundamental human rights. As a consequence of gender inequalities, violence against women (VAW), including abuse by mothers-in-law in the absence of partners - labour migrants, is widespread. As measured by the 2012 DHS, 19% of women aged 15-49 experienced some type of physical violence between age 15 and the time of the survey. Other estimates are as high as 62 to 76% of households.[31] Three in five women agreed with reasons justifying wife beating; only one in five had sought assistance. Early marriage is also of concern. According to the 2007 TLSS, women age 15-19 who were married or in union accounted for 8.5% of registered marriages[32]; according to the 2005 MICS, the percentage was 6.4%.[33] Early-married women are mostly rural women with incomplete secondary education. They are more likely to marry older men and tend to have more children.

2.2 The Role of External Assistance

International cooperation organizations in Tajikistan are classified in three categories[34]: i) multilateral cooperation; ii) bilateral cooperation agencies; and iii) non-governmental organizations (NGOs) and private foundations. Relations between international cooperation organizations and the Government of RT are conducted within the framework of the 2012 Shared Principles for Cooperation. The landscape of foreign aid in Tajikistan is constantly changing. Cooperation with global programmes or vertical funds providing aid to address specific challenges has increased, such as the fight against AIDS, tuberculosis and malaria. Looking ahead, while some partners have or are gradually phasing out (e.g., Sweden, DFID, GFATM), new ones are expanding their activities (e.g., Government of China, RusAid). It is evident from table 3 that there has been a substantial increase in total net Official Donor Assistance (ODA) disbursements to Tajikistan, from $80.67m in 2003 to $162.79m in 2012.

Table 3: ODA Disbursements to Tajikistan and Selected Countries 2003-2012 USD Million

Year	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Kazakhstan	232,93	208,12	152,6	100,95	186,03	234,18	177,00	98,38	34,12	36,67
Kyrgyz Republic	113,57	111,44	125,89	125,55	120,38	146,76	140,19	159,77	176,52	140,04
Tajikistan	80,67	92,4	105,11	92,02	106,24	143,55	141,05	164,63	152,56	162,79
Turkmenistan	16,82	11,43	11,89	5,45	1,49	-0,87	13,63	11,54	12,44	13,47
Uzbekistan	169,6	208,79	129,82	101,62	110,68	113,67	77,26	84,09	50,29	70,01

Source: OECD DAC

As table 4 depicts, the main ODA providers in 2011-2012 to Tajikistan were the Asian Development Bank, the International Monetary Fund, the European Union, the Islamic Development Bank, the World Bank and GFATM. Among bilateral cooperation agencies, the major donors were the governments of Germany, the United States, Japan and Switzerland.

[31] United States Department of State, Bureau of Democracy, Human Rights and Labour, Country Reports on Human Rights Practices for 2012, Tajikistan 2012 Human Rights Report.
[32] Tajikistan Living Standards Measurement Survey 2007. Indicators at a Glance, 2009.
[33] Tajikistan: Monitoring the Situation of Children and Women. Multiple Indicator Cluster Survey (MICS), 2005.
[34] Foreign Aid Report 2012.

Table 4: Top Aid Providers to Tajikistan 2011-2012 Average USD Million

Asian Development Bank	67
Germany	41
United States	36
Japan	34
International Monetary Fund	30
European Union	28
Islamic Development Bank	25
World Bank (IDA)	24
Switzerland	19
GFATM	17

Source: OECD-DAC www.oecd.org/dac/stats

In comparison, major UN agency financial contributions (Regular Resources) to Tajikistan were provided by the United Nations Development Programme (UNDP) ($4.75m), the United Nations Children's Fund (UNICEF) ($2.08m) and UNFPA ($1.00m).[35]

[35] OECD Query Wizard for International Development Statistics, accessed 14 May 2014.

PART 3: UNFPA COUNTRY PROGRAMME 2010-2015

This part of the evaluation report provides basic 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 and the financial resources at the disposal of the CO.

3.1 Introduction

The relationship between the Government of RT and UNFPA is governed by the Standard Basic Assistance Agreement (SBAA) signed by the government and UNDP on 1 October 1993. UNFPA opened its Tajikistan CO in 1995. Until 2000, Tajikistan received support within the framework of the UNFPA sub-regional programme for six Central Asian countries.[36]

The 3rd UNFPA CP 2010-2015 is presented in the July 2009 Country Programme Document (CPD), approved by the UNDP/UNFPA Executive Board, and in the two instruments that guide the implementation of the CP: the Country Programme Action Plan (CPAP), signed by the Government of RT and UNFPA, and the Annual Work Plans (AWPs), signed by UNFPA and the concerned Implementing Partners (IPs). It was designed within the strategic frameworks of the National Development Strategy (NDS) 2010-2015 and the United Nations Development Assistance Framework (UNDAF) 2010-2015 at the country level and the UNFPA Strategic Plan 2008-2011 at the corporate level. In early 2012, the CP was aligned to the revised and extended UNFPA SP 2008-2013 without making any fundamental changes. No alignment was undertaken with the new UNFPA SP 2014-2017 pending development of the 4th Tajikistan CP.

The overall goal of the UNFPA CP is to continue making a contribution to the overall stability and to poverty reduction in Tajikistan. The CP focuses UNFPA's assistance on three programmatic areas:

- Reproductive health and rights (RH);
- Population and development (PD); and
- Gender equality (GE).

Through its outputs and outcomes, the UNFPA CP intends to contribute to two of the four UNDAF outcomes:

- PD and GE[37] contribute to UNDAF Outcome 1: good governance and economic and social growth are jointly enhanced to reduce poverty, unlock human potential, protect rights and improve core public functions; and
- RH and GE contribute to UNDAF Outcome 4: there is improved access for the vulnerable to quality basic services in health, education and social protection.

3.2 UNFPA Programmatic Response

Reproductive health and rights

The RH programmatic area is by far the largest, comprising of interventions in maternal health (MH), family planning (FP), adolescent sexual and reproductive health (ASRH) and HIV prevention. According to the CPD, this programmatic area has two expected outcomes. By the end of the CP cycle, UNFPA expects to have contributed to a stronger health care system (RH outcome 1) and to better access to and use of high-quality RH services, including services to prevent STIs and HIV/AIDS, among the most vulnerable (RH outcome 2). To achieve RH outcome 1, UNFPA planned to strengthen the capacities of RH workers to provide high-quality reproductive health care (output 1). To achieve RH outcome 2, it planned to supply health care facilities with essential RH commodities including for emergency situations (output 2), and to enhance adolescents' understanding of their

[36] UNFPA CPAP 2010-2015.

[37] Originally envisaged to contribute to UNDAF outcome 4 only, discussions during the design mission with UNFPA CO staff identified an additional pathway between the CPAP GE outcome and UNDAF outcome 1.

sexual and reproductive health needs and rights as well as their behaviour to prevent STIs and HIV (output 3).[38] The CPAP confirmed these intentions. No modifications were made to the outcomes and outputs defined in the CPD. New output-level indicators were added for output 1 and output 2. Under output 3, sex workers (SWs) were introduced as an additional beneficiary group (without associated indicators in the results framework). The early-2012 SP alignment exercise saw no change in the expected outcome or outputs. Output-level indicators were modified in all areas.[39] On the occasion of the alignment, the CO determined two sets of indicators for ASRH and HIV respectively (previously identical), whereby HIV-related indicators were changed to include SWs in addition to adolescents. However, the CP results framework, until today, does not accommodate UNFPA's work since 2013 in HIV prevention among men who have sex with men (MSM).

Since 2010, the RH programmatic area has been implemented through four projects: maternal health (TJK3R21A) and family planning (TJK3R12A) as well as adolescent sexual and reproductive health (TJK3R53A) and HIV prevention among "rural youth"[40] or "vulnerable youth"[41] (TJK3R43A). In 2012, TJK3R43 was re-titled to HIV/AIDS prevention. IPs in the area of MH are the Ministry of Health (since 2010) and the NGO Tajik Family Planning Alliance (since 2013). The MoH and TFPA are also Implementing Partners for family planning and ASRH. In HIV prevention, UNFPA partners with the Religious Committee and the Youth Committee (both since 2012) and, since 2013, with the NGOs Fidokor, Apiron and Antispid. All IPs collaborate under the NEX modality.

Population and development

According to the CPD, this programmatic area has one expected outcome - i.e., to contribute to more evidence-based government development plans at national and local levels. To achieve this outcome, UNFPA planned to improve the capacity of the Statistical Agency to conduct the 2010 Population Census (PD output 1). The CPAP confirmed these intentions. The early-2012 SP alignment exercise saw no change in the formulation of the expected CP outcome or output although by then the 2010 Population and Housing Census had already been conducted. However, output-level indicators were updated to reflect UNFPA's intention to strengthen the capacities of the Statistical Agency to collect, process, analyse and publish demographic data irrespective of the census.

Since 2010, the PD programmatic area has been implemented through one project.[42] The Statistical Agency is the only IP, since 2011 (NEX modality).

Gender equality

Prior to 2010, GE was not a stand-alone component. According to the CPD, this new programmatic area has one expected outcome: By the end of the CP cycle, UNFPA expected to have improved the coverage of high-quality social services and assistance among vulnerable groups, particularly women and refugees (GE outcome 1). To achieve this outcome, UNFPA planned to make information available for advocacy with policymakers and decision makers on gender inequality, GBV and strategies to prevent GBV (GE output 1) and to improve preventive measures and service delivery for victims of gender-based violence (GBV), with an emphasis on women and refugees (GE output 2). With insignificant reformulations to the outputs and modifications to the output-level indicators, the CPAP confirmed these intentions. On the occasion of the early-2012 SP alignment exercise, GE output 2 was modified to replace "with an emphasis on women and refugees" by "with an emphasis on women and vulnerable groups"; this change was not reflected at the outcome level given its origins in the UNDAF.

Since 2010, the GE programmatic area has been implemented through one project.[43] The Committee

[38] CPD and CPAP Planning and Tracking Tool (CPAP PTT).
[39] CPAP PTT.
[40] According to 2010 and 2011 Annual Work Plans.
[41] According to 2010 and 2011 Standard Progress Reports.
[42] TJK3P31A.

on Women and Family Affairs (CWFA) has been UNFPA's IP since 2012. In 2013, the local NGO Gender and Development was added as IP for community mobilization. Both collaborate with UNFPA under the NEX modality.

Discussions during the design mission and documentary analysis in preparation for the field mission encouraged the evaluation team to identify a more appropriate impact pathway and to reformulate expected outputs and outcomes in order to be able to better assess UNFPA's work in GE (table 5).

Table 5: Restructured Results Framework for GE

Expected GE outputs	Expected GE outcomes
National health system capacities for delivering quality services for women victims of violence are strengthened →	Provision and utilization of quality support services for women victims of violence are increased
State and civil society actors have strengthened capacities and a more critical awareness of women's human rights, with a focus on GBV and sexual and reproductive health (SRH) →	State and civil society actors increasingly seek to transform discriminatory social norms in their respective settings

Source: Evaluation team

3.3 The Country Programme Financial Structure

Allocations[44]

At the time of approving the CPD, Tajikistan was placed in group "B" for resource allocation - i.e., countries that met the threshold levels for 5 to 7 (out of 8) indicators[45], and for which an intermediate share of resources was intended. The CPD shows proposed indicative UNFPA assistance of $8.9m for 2010 to 2015 (table 6): $5.5m from UNFPA's regular (core) resources (RR) and an expected $3.4m "through co-financing modalities and/or other … resources"[46]. Of the $5.5m, $3.9m was intended for RH, $0.9m for PD and $0.4m for GE. $0.3m was allocated to cover expenditures related to UNFPA's programme coordination and assistance (PCA).

Table 6: Proposed Budget by Programmatic Area 2010-2015 (in millions of USD)

	RR	Other	**Total**	%
Reproductive health and rights	3.9	2.5	**6.4**	71,91%
Population and development	0.9	0.4	**1.3**	14,61%
Gender equality	0.4	0.5	**0.9**	10,11%
Programme Coordination and Assistance (PCA)	0.3	-	**0.3**	3,37%
Total	**5.5**	**3.4**	**8.9**	**100%**

Source: CPD July 2009

Table 7 depicts trends in actual RR allocations per year for the period 2010 to 2014. The data show a decreasing trend between 2010 and 2013. Almost 82% of planned RR has been allocated to the CO.

Table 7: Total Regular Resources Allocations 2010-2014 in USD

[43] TJK3G21A.
[44] Allocations as of May 2014.
[45] DP/FPA 2007/18: Proportion of births attended by skilled health personnel; contraceptive prevalence rate (modern methods only); adult HIV prevalence; adolescent fertility rate; under-five mortality rate; maternal mortality ratio; literacy rate among 15-24 year-old females; and proportion of population aged 10-24 years.
[46] The full quote is "through co-financing modalities and/or other, including regular, resources". The evaluation team considered the reference to RR here to be a typing error.

	2010	2011	2012	2013	2014	Total
Budget	1,089,930	879,654	865,281	818,925	832,651	**4,486,441**

Source: UNFPA Atlas List, Cognos Report

Table 8 depicts allocations by programmatic area to date compared to what was planned. The largest deviation is evident in GE, which has received 160% of planned RR.

Table 8: RR Allocation by Programmatic Area 2010-2014 in USD

	RH	PD	GE	PCA	Total
Planned RR 2010-2015	3,900,000	900,000	400,000	300,000	**5,500,000**
Actual RR allocation	2,866,012	753,282	640,888	226,260	**4,486,441**
Actual RR in % of total planned	73%	84%	160%	75%	**82%**

Source: UNFPA Atlas List, Cognos Report

Table 9 depicts annual RR allocations by Atlas project 2010-2014. No RR were allocated for HIV prevention in 2010. Maternal health has received the most.

Table 9: Regular Resources Allocations by Atlas Project 2010-2014 in USD

	2010	2011	2012	2013	2014	Total
FP	266,510	182,769	147,770	142,013	130,811	**869,873**
MH	352,909	187,502	179,093	152,023	154,896	**1,026,423**
HIV	0.00	86,677	86,687	133,743	141,379	**448,486**
ASRH	93,699	94,471	126,823	101,199	105,039	**521,231**
PD	204,555	132,135	158,661	127,405	130,525	**753,282**
GE	133,575	141,862	127,933	117,518	120,000	**640,888**
PCA	38,682	54,238	38,315	45,025	50,001	**226,260**
Total	**1,089,930**	**879,654**	**865,281**	**818,925**	**832,651**	**4,486,441**

Source: UNFPA Atlas List, Cognos Report

Total on-budget other resources (OR) for the period under review was $2,601,337 - i.e., $1,956,394 from donors for programme implementation purposes (table 10) and $686,612 from Biennial Support Budget (BSB) funds to cover management support costs. To date, total raised OR for programme implementation is 57% of planned non-RR. Reproductive health attracted 77% of what was planned - i.e., $1,926,883; PD nothing and GE 6%.

Table 10: Other Resources Allocations by Programmatic Area 2010-2014 in USD

	RH	PD	GE	Total
Planned non-RR 2010-2015	2,500,000	400,000	500,000	3,400,000
Actual OR	1,926,883	0	29,511	1,956,394
Actual OR in % of total planned	77%	0%	6%	57%

Source: UNFPA Atlas List, Cognos Report

Table 11 describes on-budget OR mobilization during the review period per Atlas project. HIV prevention attracted 71% of all OR.

Table 11: Other Resources Allocations by Atlas Project 2010-2014 in USD

	2010	2011	2012	2013	2014	Total	%
FP	210,181	26,206	53,431	118,921	5,717	**414,455**	21.18%
MH	0	0	0	34,454	52,572	**86,311**	4.41%
HIV	88,373	45,110	34,112	485,941	736,260	**1,389,797**	71.03%
ASRH	0	0	0	35,605	0	**35,605**	1.82%
PD	0	0	0	0	0	**0**	0%
GE	0	0	5,000	0	24,511	**29,511**	1.50%
Total	**298,554**	**71,317**	**92,542**	**674,921**	**819,060**	**1,956,394**	**100%**

Source: UNFPA Atlas List, Cognos Report

Table 12 shows the origins of UNFPA's actual total programme resources for Tajikistan, by RR and OR per year. Data show an almost six-time increase in OR from 7.4% of total programme resources in 2011 to 41.9% in 2014.

Table 12: Origins of Total Programme Resources RR/OR in USD

	2010	2011	2012	2013	2014	Total
RR	1,089,930	879,654	865,281	818,925	832,651	**4,486,441**
OR	298,554	71,317	92,542	674,921	819,060	**1,956,394**
Total	**1,388,484**	**950,971**	**957,823**	**1,493,846**	**1,651,711**	**6,442,835**

Source: UNFPA Atlas List, Cognos Report

In addition to OR, which is reflected in UNFPA's financial system (Atlas), the CO attracted "parallel funding" (table 13) where each collaborating partner funds its own share of a joint activity aimed at common results and independently manages its own funds. As such, parallel funding is not administered by UNFPA and does not flow through UNFPA accounts.

From the document analysis, it is unclear to what extent UNFPA considers parallel funding a co-financing modality, and thus includes it in proposed indicative UNFPA assistance to programme countries. Neither was the evaluation team in the position to verify that parallel funding reported by the CO was actually triggered by UNFPA and directly supported UNFPA-planned activities and accomplishments (rather than financing activities that were merely complementary). Nevertheless, if one were to combine OR (table 11) and parallel funding (table 13) in the case of Tajikistan, the total would amount to above $3.5m, which is what was planned in terms of non-core resources. Irrespective of this particular discussion, the amount of parallel funding is clearly an indicator for assessing development partnerships (section 4.2.7).

Table 13: Parallel Funding Contributions by Projects 2010-2014 in USD

	Partner	2010	2011	2012	2013	2014	Total
FP	**WHO, USAID, GIZ, MSD**[47]	7,100	25,274	18,950	16,321	22,700	**100,345**
MH	**WHO, UNICEF, USAID, GIZ, Aga Khan Foundation**	6,000	29,200	47,800	68,800	108,000	**279,800**

[47] Pharmaceutical research company.

HIV	**UNDP, UNAIDS, UNICEF**	20,000	20,000	38,500	22,800	33,500	**134,800**
ASRH	**WHO, UNICEF, UN WOMEN, UNDP/GFATM, Youth Committee, UNV, RCST[48], SDC**	14,800	7,300	12,500	85,717	32,800	**153,117**
PD	**UN-DESA, UNICEF, UNSD, USAID**	-	24,000	828,000	17,590	44,000	**913,590**
GE	**UNIFEM, UN Women, UNDP, UNOHCHR, UNICEF**	-	118,300	96,164	-	-	**214,464**
Total		**47,900**	**224,074**	**1,041,914**	**211,228**	**241,000**	**1,796,116**

Source: UNFPA CO

During the period under review, the CO also received contraception assistance worth $294,918 through UNFPA Commodity Security Branch (CSB) funding (table 14) for further distribution. Since 2012, UNFPA has also provided HIV rapid tests worth $250,000.

Table 14: CSB Funding for Contraceptive Assistance in USD

	2010	2011	2012	2013	2014
Contraceptives	901,177	347,673	315,942	152,940	294,918
HIV Rapid Test	0	0	156,840	263,076	250,000
Total CSB	**901,177**	**347,673**	**472,781**	**416,016**	**544,918**

Source: UNFPA, FP Project Associate[49]

Expenditures[50]

Table 15 depicts trends in total RR expenditures per year for the period 2010 to 2014. The lowest expenditures were in 2013 - i.e., $802,535 and the highest in 2010 - i.e., $1,030,606. In percentage of total RR allocations, the best performance was in 2012 (99.49%).

Table 15: Total Regular Resources Expenditures 2010-2014 in USD

	2010	**2011**	**2012**	**2013**	**2014**	**Total**
RR expenditures	1,030,606	868,827	860,847	802,535	358,064	**3,920,878**
RR allocations	1,089,930	879,654	865,281	818,925	832,651	**4,486,442**
In % of RR allocations	**94.56%**	**98.77%**	**99.49%**	**98.00%**	**43.00%**	**87.39%**

Source: UNFPA Atlas List, Cognos Report

As of May 2014, the majority of expenditures had been made in RH (table 16). Within RH, the two projects HIV prevention and FP had spent the most in absolute terms. The lowest expenditures were in ASRH and GE. Table 17 breaks down this information into RR and OR per programmatic area. In terms of expenditures in percentage of actual allocations as of May 2014, FP demonstrated the highest project implementation rate (91.56%); HIV the lowest (65.53%). However, these figures need to be interpreted with differing fund disbursement modalities in mind. Table 20 below demonstrates very high annual implementation rates for all projects.

[48] Red Cross Society Tajikistan.
[49] The cost of CSB is not included in country budget expenditures. These data are also available at http://myaccessrh.org/rhi-home except for HIV rapid tests.
[50] Expenditures as of May 2014.

Table 16: RR & OR Expenditures by Project 2010-2014 in USD

	Actual allocations	% of total actual allocation	Expenses	% of actual allocations	% of total expenses
MH	1,071,780	15.12%	**931,809**	86.94%	16.10%
FP	1,284,328	18.12%	**1,176,018**	91.56%	20.32%
ASRH	556,837	7.86%	**491,919**	88.34%	8.50%
HIV	1,838,282	25.94%	**1,204,608**	65.53%	20.82%
PD	753,282	10.63%	**664,183**	88.17%	11.48%
GE	670,398	9.46%	**585,988**	87.41%	10.13%
PCA	226,260	3.19%	**197,389**	87.24%	3.41%
BSB	686,612	9.69%	**534,599**	77.86%	9.24%
Total	**7,087,779**	**100%**	**5,786,513**	**81.64%**	**100%**

Source: UNFPA Atlas List, Cognos Report

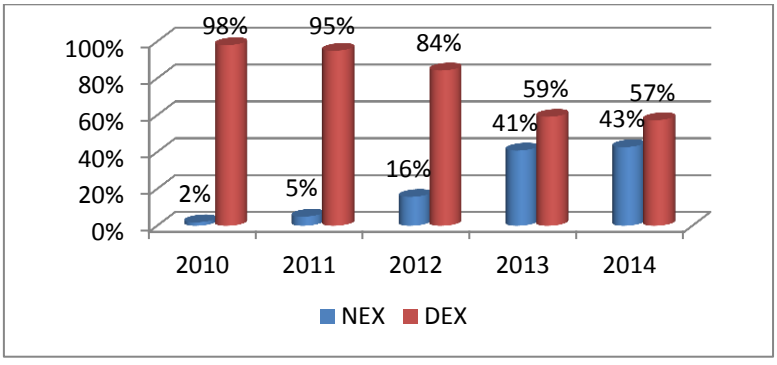
Table 17: Total RR & OR Expenditures by Programmatic Area 2010-2014 in USD

Year	Funds	RH	PD	GE	PCA	BSB	Total
2010	Regular	654,071	204,500	133,381	38,654	0	**1,030,606**
	Other	298,556	0	0	0	99,009	**397,564**
2011	Regular	55,367	125,261	141,590	51,609	0	**868,827**
	Other	66,905	0	0	0	101,231	**168,136**
2012	Regular	537,428	157,562	127,622	38,235	0	**860,847**
	Other	86,904	0	5,000	0	160,207	**252,110**
2013	Regular	522,084	126,296	115,478	38,678	0	**802,535**
	Other	654,686	0	0	0	120,393	**775,079**
2014	Regular	234,118	50,564	43,168	30,213	0	**358,064**
	Other	199,235	0	19,750	0	53,761	**272,745**
Total		**3,804,354**	**664,183**	**585,988**	**197,389**	**534,599**	**5,786,513**

Source: UNFPA Atlas List, Cognos Report

The CO is increasingly implementing its projects through the NEX modality. As shown in figure 6, the utilization of funds through the NEX modality in 2010 was 2% of total expenditures; in 2014 it is expected to be 43%.

Figure 6: Fund Utilization Modality 2010-2014



Source: UNFPA Atlas List, Cognos Report

During the period 2010-2014, UNFPA had ten national IPs in Tajikistan: five governmental and five NGOs. Table 18 describes expenditures of funds by IP through the NEX modality. Besides the MoH, the IP for MH, FP and ASRH since 2010, each of the three HIV-related NGOs have spent the most funds. They became IPs only in 2013.

Table 18: Total NEX Expenditures by UNFPA Implementing Partner 2010-2014 in USD

Implementing Partner	2010	2011	2012	2013	2014	Total	in % of total NEX
Statistical Agency	-	11,617	44,218	20,544	-19	**76,359**	7%
Youth Committee	-	-	26,355	17,122	10,263	**53,740**	5%
MoH	27,365	40,057	58,275	69,130	32,093	**226,920**	19%
Religious Committee	-	-	23,807	21,667	0	**45,473**	4%
CWFA	-	-	21,965	2,590	5,831	**30,386**	3%
NGO Gender and Development	-	-	-	7,495	10,890	**18,385**	2%
NGO Fidokor	-	-	-	145,238	48,929	**194,168**	17%
NGO Apiron	-	-	-	138,042	78,823	**216,865**	19%
NGO Antispid	-	-	-	183,200	68,567	**251,767**	22%
NGO Tajik Family Planning Alliance	-	-	-	39,081	13,929	**53,009**	5%
Total	**27,365**	**51,674**	**174,619**	**644,110**	**269,306**	**1,167,073**	**100%**

PART 4: FINDINGS

This part of the evaluation report provides an assessment of the performance of the UNFPA 3rd CP 2010-2015 four-and-a-half years into its implementation against indicators of achievement developed by the evaluation team and shared with the UNFPA CO for comments.[51] It is structured along the evaluation criteria and corresponding evaluation questions.

Evaluation findings are clearly highlighted in bold in this maid body of the report. For ease of reference, they are also listed in annex 2. A summary of and comments on findings can be found in part 6 of this report, the conclusions.

4.1 RELEVANCE

This chapter assesses the relevance of UNFPA's CP. Relevance is defined as the extent to which the CP (i) corresponds to beneficiary needs at country level; (ii) is responsive to government priorities; and (iii) is consistent with UNFPA corporate strategies and international agendas.

EQ1: To what extent is the UNFPA country programme consistent with beneficiary needs and government priorities?

4.1.1 Alignment with the Needs of UNFPA Beneficiary Groups

Finding 1: UNFPA support is consistent with important rights and needs of women and girls, notably to change widespread harmful gender stereotypes and practices, prevent unwanted pregnancies and HIV, to make motherhood safer and to protect those experiencing violence.

UNFPA support for preventing VAW and protecting victims of violence as well as for improving women's sexual and reproductive health is consistent with important rights and needs of women and girls. According to the literature, and confirmed by interviewees, traditional attitudes and customs have resulted in a subordinate status for women in Tajikistan, particularly in rural and remote areas. Forced into early, unregistered and sometimes polygamous marriages, girls are less likely to enjoy post-secondary education. Young women do not enter the labour market and are thus overly dependent on their husbands and in-laws and vulnerable to violation of their rights, including their sexual and reproductive health rights. Male labour migration, a mainly rural phenomenon, puts stress on families, with migrants often failing to send remittances or to return home. Many women therefore suffer from low self-esteem. Violence and discrimination against women, and particularly domestic violence, is an acute problem in Tajikistan; according to the US State Department[52] one of the most significant human rights problems in the country. However, there are no official data and under-reporting occurs for fear of stigmatization, reprisal or inadequate response by the police and judiciary. Women lack access to RH services and suffer from complicated pregnancies. Divorces and female suicides[53] are omnipresent. The May 2013 Tajikistan Post-2015 Consultations, co-organized by UNFPA, included representatives of women's associations, women leaders and labour migrant wives. The outcome reflected a desire for moving beyond barriers imposed on women by traditions, persisting social norms, attitudes and stereotypes, and physical distance to facilities. Of particular concern was the tendency for girls to marry early in life and the extent of domestic violence.

[51] See evaluation matrix in annex 2.

[52] United States Department of State, Bureau of Democracy, Human Rights and Labour, Country Reports on Human Rights Practices for 2013, Tajikistan 2013 Human Rights Report.

[53] See also US Department of State Tajikistan 2012 Human Rights Report: "continued trend of female suicides in some rural areas". The 2014 WHO report "World Suicide Report "Preventing suicide: a global imperative" provides statistics, while categorizing Tajikistan as a country with low vital registration coverage, a high proportion of indeterminate causes or no recent results.

Participants also pointed out that maternal mortality levels remain worryingly high. They expressed doubt that official medical statistics reflect the true situation and noted that despite many laws, policies and programmes, there was little progress towards GE.

Finding 2: UNFPA interventions reflect the sexual and reproductive health needs of young people in a wider sense, encompassing inequalities and their overall health and well-being.

Tajikistan is categorized as a young nation with the 15-29 age group comprising 31% of total population and almost 70% of the population under 30. Young people face significant economic and social challenges, including in the area of sexual and reproductive health where many, particularly in rural areas, lack the necessary information, knowledge and access to counselling and contraceptives causing serious health hazards and endangering lives. Numerous boys and girls grow up accepting and reinforcing gender stereotypes. Cases of suicides, radicalization of youth and involuntary labour migration were often mentioned by interviewees and group discussion participants as negative trends. Young men and women also took part in the aforementioned Post-2015 Consultations where they identified education, health, employment, good governance and inequalities as major challenges. Participants urged that special attention be given to gender equality and the necessity to alter traditional opinions and societal gender norms such as early marriages, in particular in rural areas. Concerned about the high level of HIV and STIs, they agreed on the importance of promoting health lifestyles. UNFPA's interventions to engage men and boys, to promote sexuality education, to change HIV-related behaviours and establish youth-friendly health services all reflect such concerns.

Finding 3: In an environment of unequal access to HIV services for key populations and widespread stigma and discrimination, UNFPA support highly corresponds to the needs and human rights of men who have sex with men and female sex workers.

According to recent global research conducted in collaboration with UNFPA, men who have sex with men (MSM) are 19 times more likely to acquire HIV than the general population; female sex workers (SWs) are 14 times more likely to have HIV than other women.54 UNFPA support for NGO services for HIV key populations and for changing mind sets - e.g., through the Religious Committee - highly corresponds to the needs and human rights of MSM and SWs in Tajikistan where the availability of targeted interventions in public institutions is generally low and preventive efforts for key populations are lagging behind. In addition, pervading stigma and discrimination, including on the part of civil servants, bring shame and fear of punishment, disclosure and rejection to SWs and MSM, creating difficulties reaching them. At the time of the field mission, non-governmental interviewees were very worried about the Ministry of Interior detaining SWs in Dushanbe, apparently forcing them to undergo HIV/STI tests and entering their personal details into a special electronic database in a campaign to fight prostitution. Interviewees observed SWs being driven underground where they become more difficult to reach, thus potentially intensifying threats to their individual, but also public health. Homosexual relations are not illegal in Tajikistan; however homosexuality is widely a taboo subject. At the time of the field mission, UN country team (UNCT), non-governmental interviewees and group discussion participants were equally concerned about deteriorating access for MSM to HIV-related information and services because of acute police harassment. Such voices were echoed in media reports.[55] The evaluation team took note that members of the Joint HIV/AIDS Group, including UNFPA, were coordinating a joint response to the events, which subsequently included a letter to the Republican AIDS Centre as the main governmental body for coordinating the implementation of the National HIV Programme.

[54] Referenced in Report on the implementation of the decisions and recommendations of the Programme Coordinating Board of the Joint United Nations Programme on HIV/AIDS of 12 July 2013 (DP/2013/46-DP/FPA/2013/16).

[55] For example: http://www.eurasianet.org/node/68921; http://www.amnesty.org/en/for-media/press-releases/police-seize-sex-workers-and-men-believed-be-gay-tajikistan-s-new-morality-0.

Finding 4: The CP responds to civil society demands for more and better quality social and demographic data and evidence for policy-making and decision-taking.

While not representative of Tajikistan's entire population, youth and civil society representatives participating in the Post-2015 Consultations felt that governmental decisions were not sufficiently based on available data and information, and that evidence used by the state - e.g., on vulnerable population categories, was not always reliable and did not necessarily reflect the real situation. Interviewees met during the design and field missions echoed this perception, while acknowledging uneven improvements. They confirmed that UNFPA support reflects such demands for more and better quality data and evidence for decision-taking. Besides building the capacities of the Statistical Agency, it has also generated new types of social and demographic data and analysis in response to public needs and as input into policy dialogue - e.g., on ageing, contraceptive prevalence, domestic violence and early marriages.

4.1.2 Alignment with National Policy and Institutional Frameworks

Finding 5: Addressing important capacity and financial gaps, the CP is in full support of the Government of RT's political commitment to improve maternal health and family planning.

Tajikistan has a comprehensive policy framework for improving RH, including maternal health and family planning, addressed and highlighted in the NDS 2010-2015, the recently updated (but not yet adopted) Law on Reproductive Health and Rights, the Comprehensive National Health Strategy 2010-2020 and numerous other policy documents. Despite such political commitments, however, the evaluation team noted that policy documents often do not reflect modern approaches in planning, programming and management; neither are they supported by a monitoring mechanism nor budgeted, and state expenditures are not reported, although the Government of RT considers RH services part of a basic benefit package. In general, public spending on health has been and remains very low at 2.2% of GDP in 2013, barely enough to cover salaries of health professionals and utility service. Despite its standing among the government's professed priorities, domestic resources for RH are insufficient to cover needs.

Finding 6: UNFPA interventions serve to uphold the daily application of state commitments on HIV/AIDS as stipulated in national laws and policies.

According to the ICPD Beyond 2014 Tajikistan Implementation Profile, the level of government concern about HIV/AIDS is major.[56] Indeed, policies and programmes are increasingly addressing HIV/AIDS as a development challenge. Slowing down the spread of HIV/AIDS is a priority of the NDS and of the Living Standards Improvement Strategy (LSIS) 2013-2015. The Comprehensive National Health Strategy 2010-2020 defines measures to ensure that everyone has access to HIV/AIDS prevention, treatment, care and support. It highlights the needs of pregnant women, children, young people and most at risk populations. The National HIV/AIDS Programme 2011-2015 aims to hold the HIV epidemic in its concentrated stage whereby HIV prevalence among PWID, MSM and SWs should not exceed 20%. The 2005 Law on HIV and AIDS, updated in March 2014 with the support of the UN Joint HIV Advocacy Project (UNJAP), stipulates a national response to HIV prevention and care for vulnerable and high-risk groups as well as the need to decrease stigma, discrimination and violence. However, the national HIV/AIDS response is largely dependent upon financing by international donors.[57] Furthermore, as expressed by interviewees, there are significant gaps in carrying out commitments to address the HIV epidemics among key populations. Reliable estimates of HIV incidence among MSM and SWs are not available, making an evidence-based response difficult for all concerned actors. Moreover, as evidenced in interviews and mentioned above in connection with

[56] 2009 data.

[57] According to the UNAIDS 2013 Global Report, Tajikistan belongs to the group of countries whose dependency of the national HIV response on international sources as a percentage of the total international and domestic public funding is 75 to 100%.

recent police operations against SWs and MSM, there seem to be different views on how to achieve set goals. Civil society and UNCT representatives fear that human rights are being violated and that backtracking on important accomplishments could occur.

Finding 7: Thanks to its close cooperation with the Statistical Agency, the CP is embedded in the national system of official statistics.

According to the March 2013 UNECE Global Assessment, the Tajik National Statistical System is under increasing stress for timely, high quality and internationally comparable information, and this despite severe human, financial and technical resource constraints. In the course of the changes following independence in 1991, the statistical system of Tajikistan was confronted with the necessity, but also the opportunity, for a rapid and complete transformation. Although further improvement can still be achieved, the Statistical Agency has developed considerably over the last twenty years and can be considered, in many respects, a professional institution. As such, UNFPA's close collaboration with the Statistical Agency in the area of social and demographic, including gender, statistics, and in particular the Population and Housing Census, can help overcome important institutional limitations and contribute to effective policymaking. It was highly welcomed by interviewed Statistical Agency staff, both at central and local levels.

Finding 8: UNFPA support is completely in line with priorities set by the national gender policy framework, also thanks to its partnership with the national women's machinery.

Tajikistan has signed on to a range of international goals and conventions that mandate GE, including the MDGs, the ICPD PoA and CEDAW. National laws, policies and strategies in the area of GE are well established and being further developed. While some interviewees perceived the government's emphasis to be more on higher education and women in management, important commitments also exist to improve the lives of disadvantaged women. Inter alia, the NDS 2010-2015 recognizes the poor understanding of the need to address gender issues on the part of public employees and the limitations of the statistical base and data collection system to advance the cause of GE. Among the priorities of the LSIS 2013-2015 are the reduction of obsolete gender stereotypes that impede women's development and the prevention of VAW. In June 2010, the Tajikistan Family and Criminal Codes were amended to change legal marriage age from 17 to 18 years of age. After a decade-long process, in March 2013, the Parliament passed the country's first Law on the Prevention of Violence in the Family, followed by the approval of a National Programme and Action Plan on the Prevention of Violence for 2014-2023. However, domestic resources for advancing GE are insufficient. Specifically, while the structural and financial capacities of the national women's machinery, the Committee on Women and Family Affairs (CWFA), have been strengthened over the years, in 2013, the CEDAW Committee remained concerned about the very low percentage of the national budget allocated to it - i.e., 0.7%.[58]

EQ2: To what extent is the CP consistent with the MDGs, the ICPD agenda and UNFPA strategic plans?

4.1.3 Support for the MDGs, the ICPD Agenda and Other International Commitments

Finding 9: MDGs 5 and 6 (and the future Sustainable Development Goals), the ICPD agenda and Tajikistan's CEDAW commitments occupy centre stage in UNFPA's work.

At the international level, UNFPA's 3rd CP in Tajikistan, according to the CPD, is aligned with the MDGs. The CPAP situates cooperation between UNFPA and the Government of RT within the context of the ICPD PoA, the 4th World Conference on Women, the UN Millennium Declaration and the

[58] In 2013, 15 staff members in the Dushanbe central office and 200 staff in offices at district, municipal and regional levels, with a budget of TJS 1,786,360, approximately USD 361,415 (source: CEDAW/C/TJK/Q/4-5/Add.1).

World Summit on Sustainable Development. Evidence shows that - in line with the UNFPA SP - the MDGs (mainly 5A and 5B) and the ICPD agenda indeed occupy centre stage in UNFPA's work, as does MDG 6A on HIV/AIDS. At the policy level, the CO, together with UN sister agencies has actively facilitated ICPD Beyond 2014 and post-2015 Sustainable Development Goals (SDGs) consultations, both intended to feed into their respective regional and global processes, but also into the process of preparing the new NDS for Tajikistan. Furthermore, it is noteworthy that collaboration between UNFPA and the Government of RT has been mutually extended in aid of follow-up to and reporting on commitments under CEDAW (box 3) and the Universal Periodic Review (UPR).

Box 3: Tajikistan's Commitments under CEDAW (Extract)

In recent years, the UPR and CEDAW[59] have queried the persistence of gender stereotypes, limited access to adequate health-care services for women, especially those in rural areas and those affected by HIV/AIDS, VAW and early marriages in Tajikistan. *Regarding gender stereotypes,* the Committee urged Tajikistan:

(a) To adopt … a comprehensive strategy to modify or eliminate patriarchal attitudes and stereotypes that discriminate against women…;

(b) To expand public education programmes on the negative impact of such stereotypes on women's enjoyment of their rights, in particular in rural areas;

(c) To use innovative measures that target the media to strengthen understanding of the concept of equality of women and men and to ensure that curricula and teaching materials promote a positive and non-stereotypical portrayal of women and men;

(d) …;

(e) ….

Regarding health, the Committee called upon Tajikistan:

(a) To increase access for women and girls, in particular in rural and remote areas, to basic health-care services and to address obstacles to women's access to health care;

(b) To strengthen the maternal mortality reduction programme by addressing the limited access to obstetric services, developing the reproductive health infrastructure and increasing the number of skilled personnel;

(c) To develop strategies to combat HIV/AIDS with a gender perspective, to strengthen the provision of free antiretroviral treatment to all women and men living with HIV/AIDS, including pregnant women so as to prevent mother to child transmission, and to ensure that women and girls living with HIV/AIDS are not subjected to stigmatization and discrimination.

Regarding VAW, the Committee urged the Government of RT to give priority attention to combating all forms of violence against women and girls, including by:

(a) Amending the Criminal Code, the Criminal Procedure Code and other relevant national legislation in order to enforce, among other things, the provisions of Law No. 954 (2013) on prevention of violence in the family…;

(b) Developing a comprehensive national action plan for the prevention of all forms of violence against women, the protection and

[59] The Convention on the Rights of the Child (CRC) Committee and the Committee against Torture (CAT), in their February 2010 and November 2012 concluding observations respectively, also expressed concern about gender discrimination and domestic violence in particular. Observations are not reflected here since UNFPA was not part of those processes.

support of victims and punishment of the perpetrators and ensuring its full implementation, monitoring and evaluation;

(c) Providing mandatory training for judges, prosecutors and police officers on the strict application of legal provisions criminalizing violence against women;

(d) Raising public awareness of Law No. 954 (2013) on prevention of violence in the family and other legislation relating to violence against women through the use of media and educational programmes, as well as raising the awareness of law enforcement personnel, health service providers and teaching staff regarding all forms of violence against women and girls;

(e) Providing free legal aid, adequate assistance and protection to women victims of violence by establishing an adequate number of shelters, especially in rural areas, in cooperation with non-governmental organizations;

(f) Collecting statistical data on all forms of violence against women, including domestic violence, disaggregated by sex, age and relationship between the victim and the perpetrator, and undertaking or supporting studies and/or surveys on the extent and root causes of violence against women.

Regarding early marriages, the Committee urged the Government of RT to effectively enforce its legislation that prohibits polygamy… and to protect the rights of women and their children in existing polygamous and religious marriages, regardless of their registration status.

Source: Concluding observations on the combined fourth and fifth periodic reports of Tajikistan, October 2013

4.1.4 Consistency with UNFPA Strategic Plan

Finding 10: The UNFPA Tajikistan CP was consistent with previous UNFPA Strategic Plans; it is aligned with current corporate-level outputs and associated outcomes.

The UNFPA Tajikistan CP was consistent with and is in support of the current UNFPA Strategic Plan (SP). In the area of RH, it mirrors UNFPA's two clusters, introduced in 2011, one to focus on women's reproductive health and the other to focus on adolescents and youth. Meanwhile, it also includes a strong focus on HIV key populations. Based on documentary analysis and interviews, box 4 displays the understanding of the evaluation team how the CP aligns with respective SP outputs and outcomes. As regards the current SP, it found that:

- current work in maternal health, especially to strengthen the role of midwives, reform emergency obstetrics care (EmOC) and implement the Minimum Initial Service Package (MISP) for RH in crisis situations, is in line with the UNFPA SP 2014-2017;
- family planning and reproductive health commodity security, one of the CO's largest areas of intervention, are at the core of UNFPA's SP 2014-2017;
- the HIV prevention project is well aligned with the UNFPA SP 2014-2017 intention to increase national capacities to deliver HIV programmes that are free of stigma and discrimination[60];
- the CO's investments in adolescents and youth are consistent with UNFPA's vision and the increased emphasis under the SP 2014-2017 on young people as key beneficiaries;
- the bulk of the PD programmatic area contributes to the UNFPA SP 2014-2017 commitment to

[60] SP output 4 "increased national capacity to deliver HIV programmes that are free of stigma and discrimination, consistent with the UNAIDS Unified Budget Results and Accountability Framework (UBRAF) commitments". According to the UNAIDS Division of Labour Matrix, contained in the UNAIDS 2011-2015 Strategy, UNFPA and UNDP are convenors for empowering MSM, SWs and transgender people to protect themselves from HIV infection and to fully access antiretroviral therapy. Together with UNICEF, UNFPA is also convenor for empowering young people to protect themselves from HIV.

strengthen capacity for production and dissemination of quality disaggregated data; and

- CO priorities in the area of GE, especially as regards GBV and engaging men and boys, are well aligned with the current UNFPA SP 2014-2017.

Box 4: Alignment of UNFPA Tajikistan CP with UNFPA Strategic Plans

CP 2010-2015	SP 2008-2011[61]	SP 2008-2013	SP 2014-2017[62]
MH	Goal 2, Outcome 2.2	Outcome 2, Outputs 4, 5, 7	Outcome 1, Outputs 3, 5
FP	Goal 2, Outcome 2.3	Outcome 3, Output 8	Outcome 1, Outputs 2, 5
HIV prevention	Goal 2, Outcome 2.4	Outcome 4, Output 11	Outcome 1, Output 4
ASRH	Goal 2, Outcome 2.4	Outcome 6, Outputs 15, 16	Outcome 1, Output 1 Outcome 2, Outputs 6, 7
PD	Goal 1, Outcome 1.3	Outcome 7, Output 17 Outcome 1, Output 1	Outcome 4, Outputs 12, 14
GE	Goal 3, Outcome 3.2	Outcome 5, Output 12, 13, 14	Outcome 3, Outputs 9, 10, 11

Source: Evaluation team

Finding 11: While not having determined a unified approach across the CP, the CO has paid high attention to mainstreaming women's and young peoples' concerns in CP design and implementation. Emergency preparedness is an obvious component of the CO's work.

The evaluation has also assessed the extent to which corporate cross-cutting issues - i.e., gender, young people, HIV/AIDS, South-South cooperation and emergency preparedness have been incorporated in the CP. Of these, only emergency preparedness was explicitly determined in the Tajikistan CPAP as cross-cutting for all three programmatic areas. Generally speaking, there is no evidence that the CO developed strategies for mainstreaming corporate cross-cutting issues in its work to ensure a strategic approach across the CP; neither goals nor budgets were set.

In line with UNFPA's vision (also referred to as "bull's eye"), women are obviously at the centre of UNFPA's work in Tajikistan, in all programmatic areas. The evaluation team also recognizes the gender dimension to the not catered for needs of MSM. While most interviewees did not think to question the strong emphasis on women and girls, very few reminded the evaluation team that a gender-sensitive approach also required organizations, including UNFPA, to consider the needs of the male population. In that sense, the evaluation team tried to convene a RH discussion with men, unfortunately unsuccessfully.

Young people are the specific focus of the ASRH project and - over the years to a lesser extent - of the HIV prevention project. There is evidence that a particular emphasis has also been put on targeting and pro-actively engaging young people, and particularly boys, in activities to transform gender relations and to prevent VAW. The voices of young people and their concerns have been heard in important national processes, co-organized by UNFPA, related to ICPD Beyond 2014 and the post-2015 SDGs.

HIV is the main emphasis of the HIV prevention project. Apart from this, the evaluation team observed efforts to share information, offer HIV tests (MH), make condoms available (FP) and to change attitudes and behaviours (ASRH, GE) through the other programmatic areas with the exception of PD.

The CO has sought opportunities to promote South-South cooperation or rather exchange between Tajikistan and other countries of Central Asia and Eastern Europe. The evaluation team noted that it has relied on, for instance, Russian and Kyrgyz consultants, has organized study tours to Moldova, and enabled partners to participate in regional events such as in Turkey and the Ukraine.

[61] CPAP 2010-2015.
[62] Based on SP 2014-2017 Annex 1 (IRF).

UNFPA has identified Tajikistan as an emergency focus country in the Central Asian region. Emergency preparedness is a declared priority of the CPAP, anchored in FP. As a member of the multi-stakeholder Rapid Emergency Assessment & Coordination Team (REACT), the CO promotes SRH, including GBV and HIV, in emergencies through Minimum Initial Service Package (MISP) training[63] as well as - in acute situations - provision of dignity kits, emergency RH kits and medical equipment; it supported the elaboration of a National Action Plan for RH in Emergencies.

4.2 EFFECTIVENESS

This chapter assesses the effectiveness of UNFPA's CP. Effectiveness is defined as the extent to which CPAP outputs have been achieved and the extent to which these outputs have contributed to the achievement of the CPAP outcomes. The discussion is structured along the six CP projects. The effectiveness chapter concludes with an assessment of the extent to which UNFPA has successfully pursued partnerships with other development actors to achieve its objectives.

4.2.1 Maternal Health

EQ3a: To what extent has UNFPA strengthened national capacities, contributing to increased availability and utilization of quality maternal health services and emergency obstetric care?

Finding 12: Together with its partners, UNFPA has successfully introduced effective perinatal care in maternity houses and medical educational institutions.

Together with its partners[64], UNFPA supported the MoH with a series of inter-related activities to introduce effective perinatal care (EPC) in Tajikistan. As part of the EPC programme, UNFPA supported the development and implementation of 27 national standards and guidance on RH and maternal and neonatal health care. It facilitated and organized evidence-based advocacy (more than 45 technical meetings at different levels of the health sector), capacity-building activities (15 trainings for more than 1,000 health professionals), monitoring and mentoring (in 19 districts), cross visits (between ten maternity hospitals), external (2) and internal (21) assessments, and public awareness activities (22 television and radio programmes).[65] Consequently, in 2012, the MoH updated its provisions on the implementation of EPC. At the time of the CPE field visit, 68 maternity hospitals[66] at district and city levels were reportedly implementing EPC national standards. The evaluation team met with health professionals in 11 maternity houses and was able to observe that the EPC programme (i) was easy to understand for health professionals; (ii) was simple and practical to implement in local conditions; (iii) did not require additional financial resources; and that (iv) significant improvements in the quality of care were occurring - e.g., decrease in hospital infection[67].

UNFPA is also a key partner of the MoH for upgrading EPC, including EmOC, training programmes and curricula of graduate and post-graduate institutions in accordance with the WHO Making Pregnancy Safer Initiative[68]. Since 2010, the Tajik State Medical University, the Tajik Postgraduate Medical Institute, four nursing and midwifery colleges and nine medical schools, with UNFPA's support, have updated their respective curricula, approved by the MoH and the Ministry of Education (MoE). Interviewees confirmed that UNFPA-supported trainings were decisive in bringing educational programmes for obstetricians, gynaecologists and midwives in Tajikistan up to WHO-recommended international standards.

[63] http://misp.rhrc.org/.
[64] WHO, UNICEF, USAID, GIZ.
[65] MoH Joint Annual Reports on Health (2011, 2012, 2013); UNFPA 2010-2013 Standard Progress Reports; MoH RH/MCH Coordination Council meeting reports (2011-2013.
[66] There are a total of 200 maternity hospitals in Tajikistan.
[67] Joint Assessment of Quality of Care to Mother and Child at Hospital Level (WHO, UNFPA, USAID, GIZ), 2011.
[68] http://www.who.int/patientsafety/activities/technical/details/en/index4.html.

Finding 13: The UNFPA-supported reform of maternal health services, including EmOC, is completed. The new referral system is being implemented.

In line with the National Plan of Action on Safe Motherhood, UNFPA and its partners have continued to work with the Government of RT to reform the organizational structure of maternal health services inherited from the Soviet Union. With technical assistance from UNFPA, including a study tour to Lithuania, the MoH formulated regulations and subsequently adopted decrees on restructuring maternal and new born health care services in accordance with international standards. In 2014, a clear referral system with three levels was established to provide basic, comprehensive and specialized EmOC services: 127 1st-level rural maternity hospitals, 68 2nd-level district maternity hospital, and five 3rd-level national and oblast maternity hospitals with perinatology centres. Also as a result of this UNFPA-supported reform process, the first national perinatology centre was established in Dushanbe. Interviewees confirmed that clear guidance now exists on roles and responsibilities at each level of EmOC services.

Finding 14: With UNFPA's support, five EmOC institutions have been established and are functioning throughout the country. Ambulances provided by UNFPA are instrumental for saving the lives of hundreds of mothers and their children, including those living in remote areas.

Interviewees recognize UNFPA as a key partner of the MoH in EmOC. In 2010, thanks to UNFPA advocacy and technical advice, the MoH established by decree EmOC departments within each of the five national and oblast maternity hospitals. UNFPA subsequently supported the MoH's investments in the physical infrastructure of the EmOC centres by contributing five ambulances equipped with minimal medical equipment. During the field mission, the evaluation team visited four EmOC centres located within the national and oblast maternity hospitals in Kurgan-Tube, Kulyab, Khujand and Dushanbe. It was able to familiarize itself with their functioning and effectiveness. The MoH reported that, thanks to the ambulances, it had been possible to transfer some 300 women with complicated deliveries a year from remote areas to the next specialized level for comprehensive EmOC services.[69]

Ambulance in Oblast Maternity House Kulyab

Finding 15: Tajikistan is one of ten[70] countries in the WHO European region to have adopted and rolled out WHO's Beyond the Numbers approach, also thanks to UNFPA.

To make pregnancy safer, UNFPA has continued its efforts to promote the confidential review of maternal mortality at national level and near miss case analysis at hospital level within the framework of WHO's Beyond the Numbers (BTN) approach. MoH interviewees highlighted UNFPA's significant contribution to introducing BTN in Tajikistan, including through evidence-based advocacy and knowledge-sharing based on experience made in Moldova and the drafting of legislative documents. As a result of joint efforts, the MoH signed a decree to introduce BTN in Tajikistan. In 2010, a coordination council on maternal mortality audit was established, coordinated by the Tajik association of obstetricians and gynaecologists. In 2011, a WHO/UNFPA external assessment on implementing BTN, conducted in selected maternity houses, found that the performance and quality of care had improved and recommended to expand the near miss case analysis. Interviewees confirmed that the MoH considers BTN one of the main mechanisms for reducing maternal mortality

[69] MoH Annual Report 2011, 2012; MoH information on effectiveness of EmOC centres, 2013.
[70] http://www.euro.who.int/en/health-topics/Life-stages/maternal-and-newborn-health/activities-and-tools/beyond-the-numbers.

and morbidity. While five maternity hospitals were piloting a near miss case analysis in 2010, the number of hospitals covered by BTN has meanwhile reportedly increased to 31 nationwide. As a result of nationally-led near miss case audits of participating hospitals, the evaluation team noted that more than 60 protocols have been developed (confirmed by the evaluation team to be available and in use in Soghd, Kulyab and Dushanbe), that health professionals feel more capacitated and confident to provide quality services and manage complicated deliveries, that the number of severe complications, blood transfusions and surgical removal of organs has decreased, and that laboratory services have improved (observed by the evaluation team in Soghd, Khatlon and Dushanbe).

Finding 16: UNFPA is helping to fill the gap in essential medical supplies and medicines for EPC and EmOC.

UNFPA has also provided essential medical supplies and medicines to the MoH to implement EPC national standards and protocols and to strengthen EmOC. During the period under review, 78 maternity hospitals, including district, city and oblast maternities, received essential medical supplies. 180 maternity hospitals, including the above-mentioned and selected rural maternities, received medicines (vitamin k, hydralazine, and oxytocin). Interviewed health professionals at all levels of the MoH expressed great gratitude, especially in light of insufficient state funds for health and especially RH. UNFPA assistance was considered timely and effective. Frequent reference was made to the importance of hydralazine to manage eclampsia and related complications.

Finding 17: UNFPA has played a leading role in strengthening the role and ensuring the quality of midwifery services in EmOC.

In remote mountain areas, midwives are often the only health professionals to provide obstetric and perinatal care despite their historically limited training to provide those services. In 2011 and 2014 respectively, Tajikistan participated in two global surveys on the state of the world's midwifery, facilitated by the MoH and UNFPA. In 2012, UNFPA provided technical assistance for the MoH to develop national guidelines for professional midwives on providing EmOC, based on the WHO Integrated Management of Pregnancy and Childbirth (IMPAC)[71] toolkit. After being tested in two pilot districts (Shahrinav and Khujand) and subsequently adjusted, the guidelines were officially adopted in 2012. At the same time, with UNFPA's support, a team of 24 national midwife trainers was established to promote the midwifery programme. To date, the team has been able to train 230 midwives to provide quality EmOC services, as compared to 4,376[72] health professionals working as midwives in the country. Interviewed national midwife trainers were satisfied with the quality of the training encompassing both theory and clinical practice. Meanwhile, USAID and GIZ have joined hands with UNFPA and the MoH to strengthen the capacities of more midwives in Tajikistan.

Finding 18: Largely thanks to UNFPA, Tajikistan has a National Plan of Action on Cervical Cancer Prevention.

According to statistical reports from the National Health Statistics Centre, cervical cancer morbidity and mortality are constantly growing in Tajikistan. Conducted within the framework of the Joint Regional UNFPA/WHO Initiative on Cervical Cancer Prevention (CCP), a UNFPA-commissioned analysis of cervical cancer prevention, treatment and care and assessment of the pathology and laboratory system in Tajikistan[73] revealed that CCP suffers from limited health professional capacities, the absence of a cancer screening coordinator, unreliable data, a poor laboratory system (including absence of laboratory specialists), the absence of pap smear diagnosis, and late-stage diagnosis of the disease. Building on these and other expert insights, such as from a study tour to Lithuania, UNFPA facilitated the elaboration of a National Plan of Action on CCP, subsequently

[71] http://www.who.int/maternal_child_adolescent/topics/maternal/impac/en/.
[72] State of the World's Midwifery 2014 Report, Tajikistan Country Brief.
[73] Dr. Daiva Vaitkiene, MD, PhD: Mission report on situation analysis and needs assessment on prevention of cervical cancer in Tajikistan, 2012.

accepted by the MoH RH/MCH Coordination Council in December 2013, and currently pending approval of the MoHSP. Implementation of the Plan of Action started in 2014 with additional support from USAID and the Aga Khan Foundation. With technical assistance from UNFPA and WHO, the MoH reportedly organized a first Training-of-Trainers (TOT) on visual inspection with acetic (VIA) and colposcopy for 30 RH professionals; UNFPA also procured some necessary medical equipment.

Finding 19: UNFPA has contributed to bringing the quality of national live birth statistics and analysis in line with international standards, but data are not yet fully reliable.

In 2008, the MoH adopted the WHO International Live Birth Definition (ILBD). With the support of initially the Centers for Disease Control and Prevention and subsequently UNFPA and WHO, it started implementing the new approach, including familiarization of over 1,000 health professionals and introduction of a new information system (data collection, registration and reporting to MoH) in 68 maternity hospitals at all levels.[74] As a result of the new approach, the national indicator "perinatal death" increased to 22.9 in 2012 from 14.9 in 2007.[75] However, the evaluation team noted that a number of interviewed health managers still have poor knowledge of ILBD and that professional statisticians are lacking in the health sector, not just for understanding how to properly register perinatal deaths, but also diseases according to the International Classification of Diseases (ICD).

Finding 20: UNFPA's manifold efforts to strengthen antenatal care services, together with those of its development partners, have played a significant role in securing an increased ANC coverage. It is the only organization in Tajikistan to provide rapid HIV tests for pregnant women.

The proportion of women receiving antenatal care (ANC) services in Tajikistan has increased. Official MoH statistics depict an increase from 70% in 2008 to 88% in 2012. According to the DHS, antenatal care coverage in 2012 was 79%. UNFPA's efforts to strengthen ANC services, together with those of WHO, UNICEF, USAID and GIZ, have played a significant role. UNFPA's contributions have been manifold: In 2011, in collaboration with USAID, WHO and GIZ, a team of 24 national trainers trained over 250 RH staff and family doctors on ANC standards. The team also developed tools, information and guidance on ANC for health professionals and produced information materials for pregnant women. Accepted by the RH/MCH Council in 2013, and pending translation into Tajik, the drafts are awaiting official approval by the MoH. In 2012, at the request of the MoH, UNFPA started providing HIV rapid tests for ANC services. It is the only organization in the country to do so. [76] The amount of tests provided has grown from 100,000 in 2012, 140,000 in 2013 to 200,000 in 2014, reflecting increased commitment and capacities to cover pregnant women. MH group discussion participants appreciated the availability of rapid tests at maternity hospitals and RHCs.

Not originally envisaged in the CPD or CPAP, with funding from RusAid, UNFPA has trained 470 PHC professionals on Prevention of Mother to Child Transmission of HIV (PMTCT) at the antenatal care level in 2013/2014 and procured additional HIV rapid tests. Such capacity building activities were accompanied by public information and community mobilization campaigns in Dushanbe, Khujand, Kulyab and Kurgan-Tube to promote ANC and prevention of mother-to-child transmission of HIV and reportedly resulted in 32,000 women being covered by voluntary counselling and testing (VCT).[77] In 2013, UNFPA, together with WHO, UNICEF, USAID and GIZ, supported as assessment of the quality of mother and child health care at the primary health care (PHC) level and the implementation of ANC standards. The assessment revealed good collaboration between maternity hospitals and the

[74] MoH Annual Report; Mother and Child Department's analytical reports, UNFPA 2010 and 2011 SPRs.
[75] Annual Report of Republican Health Statistics and Information Centre of the MoH (2007 and 2012).
[76] In 2012, it was agreed and expected that UNICEF would cover 40% of pregnant women with HIV rapid tests (with GFATM funding) and UNFPA 60%. However, GFATM was not in the position to provide funding.
[77] UNFPA Regular Report to UNAIDS on project implementation; information from national, city and oblast RHCs.

PHC system. It noted well-organized and functioning family planning services in all assessed PHC facilities, which were also organizing courses for pregnant women. As recommended by the assessors, the existing national ANC standards are currently being revised.

Also in 2013, following a study tour to Malaysia and several technical meetings facilitated by UNFPA, the MoH approved a new RH indicator for women at risk group that helps to prevent unwanted pregnancies among women at risk.[78] During the field mission, the evaluation team was informed by the National RHC that all city and district RHCs and PHC facilities had started implementing the new official health statistics indicator. The evaluation team was able to confirm that RHCs in Soghd have begun collecting and entering data.

4.2.2 Family Planning

EQ3b: To what extent has UNFPA strengthened national capacities to supply essential reproductive health commodities, including those used in natural disasters and other emergency situations, resulting in increased availability and utilization of quality family planning services?

Finding 21: UNFPA remains the sole agency providing contraceptives to the public health system. Thanks to UNFPA, the number of modern contraceptives has increased from four to eight types since 2010, including contraceptive implants. The Contraceptive Logistics Management Information System has been upgraded, ensuring availability of at least three modern methods of contraception at an increasing number of service delivery points. To reduce the Government's dependency on UNFPA for contraceptive commodity supply, a national action plan to introduce a Total Market Approach is being elaborated.

Boxes of Contraceptives Stored in RHC Farkhor

UNFPA remains the sole agency providing contraceptives nationwide and for free (since 1994). Since 2010, it has supported the Government of RT to introduce additional new modern contraceptive technologies. The number of modern methods offered through the national health system has thus increased from four[79] to eight types. Thanks to UNFPA, Tajikistan was the first-ever Central Asian country to introduce contraceptive implants. Looking to lowering the Government of RT's dependency on UNFPA for ensuring contraceptive commodity supplies for its population, the CO and EECARO have started to promote a Total Market Approach (TMA).[80] A regional workshop in 2013 resulted in a draft national action plan to introduce TMA. The process of adaptation to national laws and regulation is ongoing.

Availability of contraceptives requires proper logistics, monitoring and reporting. During the period under evaluation, UNFPA followed up on the recommendations of an external assessment[81] of the paper-based Contraceptives Logistics Management Information System (CLMIS), introduced in 2005. Supported by the UNFPA Global Programme on Reproductive Health Commodity Security (GPRHCS), the CO upgraded CLIMIS to a computer-based system. It provided IT equipment and support for integrating CHANNEL, the computer software programme for managing health supplies. It organized eight trainings for over 160 RH staff on CLMIS and CHANNEL. It procured trucks for oblast-level RH warehouses to deliver commodities to district-level RHCs. During its visits to RHCs at national and oblast level, the evaluation team noted the functionality and practicality of CHANNEL. Health professionals welcomed the new software and would like to see it expanded to the district level.

[78] Women with a difficult health history.
[79] One type of oral pill, one type of injectable, one type of intrauterine device (IUD) and condoms.
[80] http://www.unfpa.org/public/supplies/pid/3591.
[81] Assessment of CLMIS System with Analysis of a Social Marketing Mechanism, 2010.

Thanks to CLMIS, the number of PHC facilities offering at least three types of contraceptives, one of the primary objectives defined by the National Strategic Plan on RH for 2014, reportedly increased to 65% in 2013 (up from an estimated 25 to 40% in 2010). Furthermore, the National RH Centre is in the position to maintain a strategic stockpile of essential RH equipment, supplies and drugs, and to coordinate reporting on the use of modern contraceptives and on new acceptors of FP methods to the State Medical Statistics. The CLMIS has reportedly also resulted in significant reduction of expenses incurred from storage and transportation of RH commodities, particularly contraceptives (from $30,000 a year prior to 2010 to $20,000 starting 2012).[82] Group discussion participants (women) were aware of different types of contraceptives and where to get them. They confirmed that contraceptives - as one woman noted "humanitarian aid" - are provided free of charge.

Finding 22: National guidelines, monitoring tools and a midwife training package have been adopted and RH academicians, teaching staff and service providers trained on modern contraceptive methods.

In parallel, based on WHO recommendations, UNFPA supported the development of national guidelines on modern contraceptives[83] and of tools to monitor and assess counselling and provision of contraceptives by clinical staff. Guidelines and tools were subsequently approved by the MoH, and the evaluation team was able to confirm that they were being used by the National RHC, with regional RHCs to follow. In this connection, UNFPA supported TOTs on contraceptive implants' insertion and removal followed by six local trainings covering over 100 RH service providers. Given the popularity of intrauterine devices (IUDs) among the Tajik population and in connection with efforts to strengthen the role of midwifes in RH (see section 4.2.1 above), it provided eight locally-certified trainings covering 80 midwives on IUD clinical insertion and removal techniques.

In an attempt to institutionalize trainings in college curricula, a UNFPA/MoH assessment (2013) of the quality of education of midwives provided by medical colleges throughout the country, especially in FP, led to the development of a unified FP training package based on WHO recommendations and guidelines on modern methods of contraception. The Republican Medical College with UNFPA support provided a number of cascade trainings on FP for regional medical colleges, departments of midwifery and nursing, which were subsequently equipped with modern anatomical models and small office and IT equipment. According to interviewees, the training package is being widely used. It is too early at this stage to assess whether quality of midwife training has improved.

Discussion group participants assured the evaluation team that health professionals provided respectful and useful consultations on family planning. While some women in Soghd mentioned the constructive involvement of their husbands in counselling sessions and decision-taking, others regretted the continued low importance given to involving men and mothers-in-law making it difficult for them to access RHCs and FP services.

Finding 23: Syndrome-based treatment of STIs based on WHO training modules introduced.

In addition, UNFPA trained 60 district-level RHCs without laboratory services to provide STI services based on the WHO syndromic case management[84] approach, allowing for provision of quality diagnostic services without women having to travel to regional or national-level RHCs, also in connection with the popular IUD insertion, which requires prior STI diagnostics and treatment.

Finding 24: Tajikistan is better prepared to respond to the sexual and reproductive health needs of its population in emergencies.

[82] UNFPA Standard Progress Reports.

[83] E.g., National Clinical Guidelines on the use of Implanon implants and on IUD insertion techniques and Methodical Recommendations on the use of different modern methods of contraceptives.

[84] http://www.who.int/reproductivehealth/publications/rtis/9789241593407/en/.

Tajikistan is prone to natural and man-made emergency situations. UNFPA has committed itself to securing funds and commodities in such cases. The last medium-scale emergency situation caused by massive rains and mud slides killing over 80 people and affecting over 10,000 persons in Kulyab was in 2010. The CO's appeal to the UNFPA Humanitarian Fragile Context Branch (HFCB) was supported with over $200,000, allowing it and its national partners to provide ten days of mobile assistance focused on SRH and psychosocial support to the affected population. Following the emergency, in 2011, with the support of the UNFPA Eastern Europe and Central Asia Regional Office (EECARO) and the International Planned Parenthood Federation European Network (IPPFEN), a Tajikistan team (composed of MoH, National RHC, TFPA and UNFPA representatives) participated in an international ToT on MISP for RH where they developed a draft National Action Plan on RH in Emergencies and were certified as MISP trainers, following which they conducted a country-based roll-out training for 20 RH specialists. In 2012/2013, the draft Action Plan was approved in 2014 by the Government of RT as a sub-component of the Health Sector National Preparedness and Response Plan.

Finding 25: UNFPA-designed campaigns informing about and promoting FP and modern methods of contraception are popular among the rural population.

Since 2005, UNFPA has supported community-based FP awareness initiatives targeting remote areas of Tajikistan. Joint monitoring visits by the MoH and UNFPA have meanwhile developed into mobile teams of qualified RH personnel equipped with RH commodities visiting hard to reach locations that still suffer from insufficient access to quality FP services. Today, these campaigns reportedly[85] cover around 10,000 people at one visit with over 5,000 women having received counselling and modern methods of contraceptives on-place. Since 2010, they have reached over 40,000 people living in hard to reach locations throughout the country.

4.2.3 HIV Prevention among Young People and Key Populations

EQ3c: To what extent has UNFPA strengthened national capacities, contributing to better knowledge of HIV among young people and increased provision of quality HIV/STI prevention services for other vulnerable groups?

Originally, UNFPA HIV prevention activities in Tajikistan focused on "rural"/" vulnerable" youth, since 2011 to date in collaboration with the Youth Committee and the Religious Committee. In time, the HIV prevention project was broadened to include HIV prevention among other key populations, to address the issue of stigma and discrimination, and to include new Implementing Partners (IPs).

Finding 26: UNFPA has enabled young people to reject misconceptions about HIV and to identify ways to prevent transmission. However, still only a very low proportion of young women and men have correct knowledge of HIV/AIDS.

HIV and AIDS is one of the biggest challenges young people face. UNFPA has helped sensitize young people through information and behaviour change communication, and by building the capacities and fostering inter-sectorial partnerships involving the RAC, the MoH, the MoE, the Youth Committee, the CWFA and the Religious Committee.

In the absence of formal sexuality education, UNFPA partnered with Y-PEER, originally established under the Youth Committee and meanwhile registered as a local NGO, to communicate about HIV and transform gender relations at the community level, with a particular focus on engaging men and youth. Support included office equipment for youth-friendly information and education centres and national ToT on peer education for 28 Y-PEER volunteers. In 2011, mobile theatres with the participation of Y-PEER volunteers were a highlight of UNFPA's collaboration with the Youth Committee, reportedly enabling it to inform and educate over 500 young rural people about how to

[85] FP SPRs 2010-2013; the evaluation team was unable to validate numbers.

prevent HIV and STIs and where to receive necessary services. UNFPA also supported the Youth Committee to establish a national mechanism for educating and certifying youth peer educators, which has meanwhile reportedly gained the support of other donors. The evaluation team received positive feedback from involved civil servants and young people on the effectiveness and importance of their collaboration with UNFPA.

UNFPA is one of the Religious Committee's very few international partners. Together, they have reached out to over 250 religious leaders, including around 40 female religious leaders, to discuss stigma and discrimination and how to prevent HIV/STIs. They also brought medical personnel and religious leaders together to discuss HIV both from a medical and spiritual point of view. Based on interviews conducted with different stakeholders, it is the evaluation team's impression that trained religious leaders have not necessarily become pro-active, but that inertia is prevalent.

Interviewed service providers and beneficiaries viewed activities to bring about behaviour change as innovative and applicable to the respective target audiences. Positive comments were made on the quality and helpful content of materials provided. However, despite UNFPA and other's efforts, the proportion of young women and men with correct knowledge of HIV/AIDS remains low, including among the focus group participants in the districts visited.

HIV prevention among sex workers and men who have sex with men

As regards vulnerable groups or key HIV populations, UNFPA has been making a positive contribution. Since 2013, it has worked intensively with sex workers (SWs) and men who have sex with men (MSM), largely funded by UNDP as principal recipient of GFATM funds. It works alongside other organizations such as USAID with its Population Services International HIV prevention project and IOM's project on HIV prevention among migrants.

Finding 27: UNFPA has strengthened the institutional capacities of and alliances between local NGOs to provide services to HIV key populations.

Since taking over the project from UNDP at the beginning of 2013, UNFPA created and has supported a network of 21 NGOs located in three regions of Tajikistan to deliver client-centred HIV/STI counselling and friendly-services for SWs and MSM.[86] It has done so through financial and technical support for three selected umbrella IPs - i.e., Apiron in Dushanbe, Fidokor in Khatlon and Antispid in Soghd - all of which the evaluation team visited during the field mission. UNFPA also built capacities of network NGOs through trainings[87], distribution of IEC materials, in-country exchange visits as well as regular monitoring and technical assistance visits. In 2012, the HIV prevention training modules underwent an independent expert review[88], which revealed that the modules were well developed and made a recommendation for its translation in local languages. Training participants contacted by phone during the field visit were very satisfied with the contents and quality of trainings such as on HIV/STI prevention, outreach work, M&E and communication. Interviewed participants were grateful for having been given the opportunity for exchange visits, and there are indications that new knowledge has been applied in individual cases.

Finding 28: Through the NGO network, UNFPA is preventing HIV among thousands of sex workers and men who have sex with men. The project is changing their behaviours, but not respect for their human rights. They continue to face stigma and discrimination.

All 21 NGOs are reportedly[89] providing services for SWs and/or MSM. Of these, besides the three umbrella NGOs, the evaluation team managed to visit six NGOs, where it held group discussions. In

[86] Compared to 12 NGOs in the case of UNDP.
[87] According to the training list provided to the evaluation team by the UNFPA CO, 26 trainings were conducted for 745 participants from network NGOs.
[88] Report on the Independent Expert Review of UNFPA Educational Training Modules, Dushanbe, 2012.
[89] UNFPA annual programme report on HIV prevention among SWs and MSM 2013.

2013, the IPs and their partners reportedly[90] reached a total of 8,637 beneficiaries: 5,992 SWs (146% of planned 4,100) and 2,645 MSM (94% of planned 2,800). During the first six months of 2014, the project reached 8,591 persons: 3,515 SWs (100.4% of 3,500 planned) and 5,076 MSM (113% of 4,490 planned). This is an increase over earlier years and in some instances an over-accomplishment of the set targets. At the same time, according to information received from the UNFPA CO, costs per client have sunk from an average $100 prior to 2013 to an average $52.[91]

The evaluation team noted the availability of IEC materials published and provided by UNDP/GFATM.[92] However, group discussion participants in Dushanbe, Khatlon and Soghd expressed concern that IEC materials were not user-friendly for less-educated audiences among target groups, and that more images and a clear and simple language would be appreciated. All visited NGOs have reportedly at all times been able to offer commodities and supplies to their clients - e.g., condoms, lubricants, hygiene kits - provided by UNDP/GFATM[93]; in Kulyab (Khatlon oblast) apparently also thanks to good relations with the RHC that has helped to bridge stock outs. At the same time, there were some, but not major, concerns among SWs in Kulyab about the quality of condoms. The evaluation team subsequently observed that inadequate storage could have played a role.

Clients, with whom the evaluation team conducted group discussions, were generally satisfied with services received. Discussions indicated that SWs and MSM participating in the project are becoming more aware and are changing their behaviours as regards HIV/STI prevention (box 5). According to UNFPA reporting[94], 4,069 SW clients undertook voluntary counselling and testing (VCT), 98% of which were tested for HIV, more than expected according to the project documentation. 1,332 MSM undertook VCT, 86% of which were tested for HIV (corresponding to 40% of all registered MSM clients). 447 SWs (7% of the total number of clients) and 139 MSM (5% of the total number of clients) received STI treatment through the referral system within the reporting period.

The project has changed the behaviours of SWs and MSM, but not respect for their human rights. Apart from in individual cases, the HIV project, underway since 1996 (implemented by UNFPA since 2013) has not yet helped to decrease the level of stigma and discrimination against SWs and MSM in the general public or among civil servants (also see chapter on relevance above), including in medical settings.

Box 5: SW and MSM Beneficiary Satisfaction with NGO HIV Prevention Services

"I am 22 years old. I have been working as SW since five years, but I only came to know about HIV and its consequences after meeting the outreach worker." (SW group discussion participant in Kulyab)

"I come to this centre every week to get condoms and IEC materials to distribute to my partners and friends who work with me. Apart from getting condoms, the outreach workers accompany us to the HIV testing centre, which is free of charge." (MSM group discussion participant in Kurgan-Tube)

"I am very thankful to this centre where I can get information and freely talk about my problem." (MSM group discussion participant in Kulyab)

"Before meeting our outreach worker, I had never heard about preventing myself against HIV; neither did I know about STIs. Now I know how to protect myself and have safe sex." (SW group discussion participant in

[90] UNFPA semi-annual report on prevention of HIV among SWs and MSM, 2014.
[91] Fidokor: $55; Apiron: $37; Antispid: $64. The evaluation team was not able to confirm these calculations.
[92] By the end of 2013, 47,384 IEC materials on HIV prevention had been distributed among SWs, and 10,037 IEC materials among MSM clients (UNFPA annual programme report 2013).
[93] Since project start, 1,308,154 condoms have been distributed among SWs, and 338,743 condoms among MSM clients (UNFPA annual programme report 2013).
[94] UNFPA annual programme report on HIV prevention among SWs and MSM 2013.

Kurgan-Tube)

Source: Evaluation team

4.2.4 Adolescent Sexual and Reproductive Health

EQ3d: To what extent has UNFPA strengthened national capacities, contributing to increased availability and utilization of youth-friendly sexual and reproductive health services and age-appropriate sexuality education?

Finding 29: UNFPA has contributed to the human rights and needs of young people being better incorporated in national development and health laws, policies and programmes.

Throughout the CP cycle, UNFPA has seized opportunities to influence youth policy development and youth mainstreaming, mainly in collaboration with different governmental entities, including the Youth Committee, the MoE and the MoH. In 2010, UNFPA partnered with the MoH, WHO and the NGO Tajik Family Planning Alliance to conduct a national assessment of legal, policy and other barriers for youth to access SRH information and services. As a result, a road map was developed. According to interviewees, the road map is guiding actions to address SRH needs of young people. For example, it included recommendations to raise the minimum age of marriage to 18 years and to promote healthy-lifestyle education (HLSE). However, other barriers are still considered to exist. Furthermore, according to interviewed civil servants, UNFPA was a key partner in developing the National Youth Policy till 2020 and the National Youth Health Development Strategy 2011-2013. ASRH concerns were also included in the National Strategy on RH till 2014, and UNFPA is considered to be playing an active role in the drafting of the next Strategic Plan on RH.

Finding 30: UNICEF Youth-Friendly Health Services centres and RHCs are providing young people with sexual and reproductive health services and commodities according to international standards, also thanks to UNFPA.

UNFPA has partnered with the MoH and UNICEF in connection with their youth-friendly health services (YFHS) programme.[95] Specifically, UNFPA facilitated the adaptation, translation, publication and dissemination of the WHO Orientation Programme (OP) on Adolescent Health for Health-Care Providers[96]. In 2012, together with the MoH, it organized four national trainings for 110 medical specialists from YFHS centres and RHCs to provide professional advice and counsel while respecting the special needs of youth. It provided YFHS centres with IEC materials and in-kind contribution of commodities (contraceptives and HIV rapid test kits) for the increasing number of clients. The evaluation team was able to confirm availability of IEC materials and commodities as well as the WHO OP manual at the eight[97] YFHS centres visited. Staff confirmed that they have gained significant knowledge, that they have started to follow standardized approaches for service provision to different client groups, and that they apply the principle of respect to all visitors and guarantee their anonymity (through a special coding procedure). Documents reviewed at the YFHS centres confirm that clients are becoming more knowledgeable about risky behaviours. Group discussion participants were satisfied with services provided.

Finding 31: With UNFPA's support, the Tajik education system is giving increased priority to healthy lifestyle, including sexuality, education, but formal introduction of the subject in secondary schools is pending.

As part of its efforts to strengthen sexuality education in Tajikistan, UNFPA, together with the Tajikistan Education Academy[98], developed and published IEC materials, textbooks and a curriculum

[95] At the time of the field mission, UNICEF had commissioned an external evaluation of the YFHS programme.
[96] http://www.who.int/maternal_child_adolescent/documents/9241591269/en/.
[97] The evaluation team visited eight of 21 YFHS centres in Tajikistan.
[98] The state institution under the MoE responsible for teacher training/re-training and HLSE.

on health lifestyle, including ASRH.[99] As agreed upon with UNICEF who had developed textbooks for 7th to 9th grade pupils, UNFPA concentrated on 10th and 11th grade students. The products - as yet only in Russian - were officially transferred to the MoE. Tajik versions are planned and the first round of testing in secondary schools envisaged for 2015. Moreover, in 2013, a healthy-lifestyle education resource centre for teachers and students was established within the Tajikistan Education Academy. UNFPA procured necessary office and IT equipment for its start-up. The evaluation team was able to confirm that the centre is functioning well, that a working group on HLS has been established under the Academy, and that, with the continuing support of UNFPA, it is conducting research, organizing events for teachers and developing manuals on HLSE.

4.2.5 Population and Development

EQ3e: To what extent has UNFPA strengthened government capacities to collect and analyse population data to address social gaps and disparities, contributing to population information being increasingly included in government laws, policies, strategies and development programmes at national and local levels?

Finding 32: UNFPA can claim credit for a good quality 2010 Population and Housing Census.

According to interviewees, recent years have seen an overall improvement in the quantity and quality (reference is made to the international standards of reliability, accuracy and timeliness) of demographic data and analysis in Tajikistan. UNFPA, as one of the Statistical Agency's key partners, even before 2010, is recognized to have played a considerable role.

Between 21 and 31 September 2010, the first year of the UNFPA Tajikistan CP, the Government of RT conducted the 2nd Population and Housing Census. It was the 2nd national population census to be carried out during the independence of Tajikistan and the first time for the population census to be accompanied by a housing census. In 2011, UNFPA conducted an independent evaluation of the census.[100] The final report revealed that activities in the preparation and enumeration phase were in line with internationally-agreed recommendations while adapted to national needs. The Statistical Agency website - www.stat.tj - made census information available to the interested public, however only in Russian and Tajik. With UNFPA's support, and based on census information, it published a report entitled 2010 Population and Housing Census Monograph summarizing key results and process-related lessons learned, a report entitled 2010 Population and Housing Census Atlas visualizing key results in the form of maps, indicators and brief texts, and continues to produce detailed statistical reports. UNFPA made credible contributions to this particular accomplishment, including trainings, equipment and study tours to Kazakhstan and Belarus. Its technical support is recognized as having played a pivotal role for conducting the census. Cascade trainings were organized in different phases throughout the country, involving more than 200 Statistical Agency staff, supervisors, controllers and enumerators. Training participants were required to undergo tests before being confirmed in their respective roles and given the necessary responsibilities. Those interviewed by the evaluation team during the field mission expressed their satisfaction with the quality and usefulness of the trainings.

Finding 33: UNFPA has helped modernize population data collection and lay the foundation for better data analysis and dissemination. However, the integration of PD issues in planning and management is not reaching decentralized levels of government.

Irrespective of the census, UNFPA has provided computer hardware and software as well as training for strengthening the capacities of the Statistical Agency to collect, process, analyse and publish demographic data. Since 2010, UNFPA has reportedly organized 108 trainings for a total of 837 mainly Statistical Agency staff, including for preparing the 2010 census. It enabled Statistical Agency

[99] Funded through UNDP/GFATM.
[100] Aura Alexandrescu: Census Evaluation Mission Report, 2011.

staff to travel to international seminars to learn about different topics including census, statistics development, emergency preparedness, population and development and population prognosis. Most training participants expressed positive feedback and thanks during telephone interview. Some claimed to be replicating trainings for colleagues at district level. In 2011/2012, UNFPA provided the Statistical Agency (Dushanbe and regional centres) with personal computers, printers, laptops and electrical power generators. During its visits to three of four regional Statistical Agency branch offices, the evaluation team observed that equipment was in working condition and being used for data processing. Furthermore, UNFPA provided technical assistance to upgrade and install EDN[101] software at oblast (regional) level Statistical Agency branch offices. The evaluation team observed that the software was appreciated and being used for consolidating and analysing demographic data received in hard copy from the districts and passing it on to the Statistical Agency HQ in Dushanbe. While time-consuming to input data manually (EDN does not accept scanned images) and thus the need to hire contractors to help, advantages experienced so far include improved data completeness and time savings. Statistical Agency regional staff expressed the wish for the same software to be introduced at district level. In 2012/2013, in collaboration with UNICEF and the UN Statistics Division (UNSD), UNFPA supported the Statistical Agency to establish and maintain a web-based integrated database - www.censusinfo.tj.

While recognizing these accomplishments, the evaluation team noted that UNFPA's capacity-building had focused on the national and oblast levels, and was not contributing to the ongoing decentralization process in Tajikistan where local governments are expected to take more responsibility for development planning and management. Interviewees also regretted that newly acquired knowledge and skills are often lost due to well-trained demographers retiring or migrating.

Finding 34: UNFPA has sponsored surveys and promoted population dynamics as part of national policy dialogue. A key accomplishment is the first-time inclusion of a population dynamics chapter in the Living Standards Improvement Strategy 2013-2015.

Besides laying the foundation for better national data collection, analysis and dissemination, UNFPA has provided financial and technical assistance for conducting specific population-related studies and surveys. It has made use of opportunities to encourage national and international partners to mainstream and make better use of available population data and analysis and to foster policy discussions on emerging issues. Noteworthy examples in chronological order are:

- *2011 National Ageing Report in Central Asia:* Conducted for the first time in Tajikistan, the survey was undertaken together with the UN Department of Economic and Social Affairs (UN-DESA), the local NGO Central Asian Gerontological Centre and the NGO HelpAge International within the context of the Madrid International Plan of Action on Ageing. The Tajikistan chapter was widely discussed at a national conference, leading to a declaration to prepare a national ageing plan and inspiring the establishment of a gerontology department in Dushanbe.
- *2012 Demographic and Health (DHS) Survey:* UNFPA provided technical support to the first-ever DHS Survey in Tajikistan, undertaken in collaboration with USAID and the Statistical Agency. A number of questions were tailored to Tajikistan. Also thanks to UNFPA, the survey was enriched with modules on domestic violence, antenatal care (ANC) as well as breast and cervical cancer. Notably, this marked the first time that representative primary data on the prevalence and nature of domestic violence were collected. In 2013, the results of the survey were discussed at a national conference. They are widely referenced in publications. The DHS also uncovered a surprisingly low contraceptive prevalence. During the CPE field mission, UNFPA, together with USAID, was undertaking an additional qualitative survey in an attempt to validate data and better understand trends.

[101] Natural Movement of Population software that compiles civil registration data for each oblast, which is then consolidated nationally. The EDN database feeds into the Demographic Yearbook and is used for performing different analyses of population dynamics.

- *Factsheet on Early Marriages:* Contributing to national policies that respond to the needs of Tajik women, UNFPA undertook qualitative research and produced a factsheet on child marriages in Tajikistan. The factsheet was disseminated and discussed on the occasion of the 1st International Day of the Girl Child in 2012.
- *LSIS 2013-2015:* Thanks to UNFPA, the Living Standards Improvement Strategy (LSIS), the concluding phase of the NDS, includes for the first time a population dynamics chapter, including a national population expenses survey. As a follow-up, UNFPA committed itself to support the Ministry of Economic Development and Trade (MEDT) to establish a basic national system for population projection in view of future socio-economic development plans.
- *ICPD Beyond 2014 Review:* In 2012, UNFPA co-organized a national-level survey and consultations in the context of the global ICPD Beyond 2014 Review. Findings from this process were presented to a regional ICPD conference in Vienna in 2013 where country representatives agreed to continue the ICPD agenda. Subsequently, at the country level, the Tajik national parliament established a National Council on PD to advance implementation of the ICPD PoA, consisting of parliamentarians as well as representatives of the Government of RT and NGOs.
- *2014 UNDP Tajikistan Human Development Report (HDR):* A 2013 UNFPA report entitled Demographic Trends in Tajikistan was used as input into the 2014 Tajikistan HDR to emphasize the connection between Tajikistan's population situation and its influence on human development.

4.2.6 Gender Equality

The present CPE has concentrated on activities and results achieved in the GE programmatic area since 2012. This is due to the fact that, in 2011, the Tajik Centre of Sociological Research "Zerkalo" evaluated the effectiveness of the GE programmatic area.[102] This timing also coincides with a cutting back of the number and range of activities to concentrate on more targeted interventions.

EQ3f: To what extent has UNFPA strengthened national health system capacities, contributing to increased provision and utilization of quality support services for women victims of violence?

In Tajikistan, there are a number of centres where women victims of violence can walk in to seek guidance on domestic violence and other problems, run either by the CWFA or local NGOs, the latter oftentimes with the financial support of the Swiss Agency for Development and Cooperation (SDC) Prevention of Domestic Violence Project (PDV), the OSCE or private donations. Shelters where victims can stay for limited time periods without fear are far and few between. In the Khatlon and Soghd oblasts (regions), the evaluation team learnt of and visited two NGO-run shelters.

Finding 35: UNFPA's initiative to pioneer victim support rooms in state maternity hospitals for temporary stay of women victims of violence is very welcome given the dearth of shelters and services in Tajikistan.

[102] https://www.linkedin.com/company/the-center-of-sociological-research-zerkalo-.The main findings of this study are: i) Students having participated in a UNFPA-supported course on women's rights demonstrate more interest in and a higher level of knowledge compared to other students; ii) RHC staff demonstrate rather high gender sensitivity regardless of their participation in gender training, possibly because RHC employees are mostly women. However, patients are not aware about the existence of RHC psychological and legal counselling services; iii) Theoretical knowledge on gender issues among civil servants is quite high, regardless of participation in UNFPA training and regardless of their sex. However, interviews revealed that considerable gender stereotypes prevailed among training participants. Moreover, not all officials are aware of the availability of national gender statistics; iv) Short trainings are not sufficient for participants to change their attitudes and to incorporate newly-acquired knowledge in their professional activities. A combination of outreach and knowledge transfer activities, including participation in conferences, courses etc. and media broadcasts, could have a more profound effect on gender tolerance.

Victim Support Room in Khujand

UNFPA has pioneered the establishment of victim support rooms (VSRs) in state healthcare facilities for temporary - post shock - stay of women victims of violence. While the original intention was to pilot the VSRs in RHCs, stakeholders concluded that staying in maternity hospitals would be easier for women seeking refuge to explain and that maternity hospitals, because of their security arrangements, would better ensure their safety against perpetrators. In May 2012, the MoH signed a letter allocating rooms for temporarily stay of women victims of violence in eight maternity hospitals throughout the country (table 19 below). The evaluation team visited five of the eight VSRs - i.e., in Kurgan-Tube, Kulyab, Khujand, Kairakkum and Dushanbe (Maternity House No. 2). They consist of one to two rooms and were simply outfitted by UNFPA with a minimum of two single and one children's bed, hygiene articles, dressing gowns and slippers, stove, dishes and air conditioner. Visited VSRs were generally in working order and, generally, group discussion participants expressed their satisfaction with and gratitude for services provided.[103] Besides procuring equipment, UNFPA has built capacities for addressing GBV and for ensuring appropriate support and referral. Inter alia, in 2012, it organized a three-day joint training for health staff managing the VSRs and police officers from surrounding police units.[104] Interviewed beneficiaries were satisfied with the training provided. UNFPA also organized information sessions for VSR staff and a wider circle of governmental and non-governmental actors engaged in the prevention of and response to VAW in their respective regions.

Stakeholders and other development actors providing a view greatly welcomed UNFPA's initiative to introduce to Tajikistan the concept and practice of temporary shelters for women victims of violence, located in maternity hospitals. They agreed that the number of existing shelters in Tajikistan was far too few and that the inhibition level for women to seek assistance at maternity hospitals was lower than elsewhere; one interviewee described it as a "soft approach". They also considered the health facilities' security arrangements and 24/7 opening hours as advantages. Many would like to see additional VSRs being opened - ideally one per district, with an emphasis on rural and remote areas, allowing for greater proximity to potential victims. The MoH and the SDC/PDV are apparently discussing the possibility of opening further temporary shelters in health facilities.

Finding 36: UNFPA-supported victim support rooms are under-utilized. This can be ascribed to deeply-engrained cultural norms and insufficient knowledge about the VSRs among women and actors working in the area of women's rights and GBV. Moreover, interviewed health personnel felt insufficiently qualified to approach and refer victims of violence.

However, knowledge of the existing shelters among actors in the area of women's rights and GBV, particularly outside Dushanbe, was scarce, with many, including within the health sector and group discussion participants, not being aware of their existence and others requiring clarification about

[103] Group discussion participants in Kurgan-Tube, despite appreciation for the shelter and services provided, were unhappy with the VSR's facilities. The evaluation team also noted that the UNFPA-provided AC was used to cool the hallway rather than the rooms. In Kulyab, the shower urgently requires renovation. The AC had not been installed because of missing parts.

[104] The training was provided by specialists from the NGO Jahon who had previously been supported by UNFPA to benefit from an internship at the Anna National Centre for the Prevention of Violence in Moscow, member of Women against Violence Europe (WAVE) (http://www.wave-network.org/). It was partly funded by the Gender Transformative Programming Initiative of EECARO. UNFPA records show a total of 16 training participants (8 health staff and 8 police officers). According to the 2012 SPR, trained health and police workers conducted home-trainings for colleagues, covering 40 health workers and 40 police officers, in total 80 persons. The evaluation team was not able to verify these data.

their intended clients. For example, do VSRs only accept victims of domestic violence? Do they only accept pregnant women? May clients bring their children? May sex workers experiencing violence approach them? What about stateless women? Are youth-friendly services provided? Other interviewees were not clear about the types of services offered, including referral. Asked about their services, VSR management responses varied, ranging from medical care to psychological support, legal advice and referral, family mediation and help finding employment.

As yet, not many women have stayed in the VSRs; from the interviews, it seems that more are seeking drop-in counselling. VSR managers keep record of their clients, however not in a unified manner. Available data are to some extent missing, inconsistent and as such unreliable and not comparable (table 19). For example, some VSRs only register overnight clients; some only register victims referred by state authorities; one claimed to register clients under false names for their protection. At the time of the evaluation, only one woman was using the visited VSRs.

Table 19: VSR Statistics

	2012	2013	2014	Evaluator Remarks
Dushanbe Maternity House No. 2	August-December 2012: 2	Since November 2013: 12 overnight clients (length of stay up to 45 days)	January-June 2014: 10	Data missing for January-November 2013
Dushanbe National Medical Centre (Karabolo)	August-December 2012: 0		January-June 2014: 20	Data missing for 2013
Kairakum Maternity Unit at Central District Hospital	August-December 2012: 2	2013: 7	2014: 7 January-June 2014: 15	Inconsistent data for 2014
Khujand City Maternity House	August-December 2012: 1	2013: 9 overnight clients	2014: 5 clients including with children (length of stay 5-7 days) January-June 2014: 23	Inconsistent data for 2014
Kulyab City Maternity House	August-December 2012: 6	12 overnight clients since 2012, 2 of which with children (length of stay 2-10 days; approx. 50 walk-ins)	January-June 2014: 22	Inconsistent data columns 2 and 3
Kurgan-Tube Maternity Unit at Oblast Clinical Hospital	August-December 2012: 0	7 overnight clients in 2013	2014: 5 January-June 2014: 10	Inconsistent data for 2014
Rasht Maternity Unit at Central District Hospital	August-December 2012: 3		January-June 2014: 13	Missing data for 2013
Vahdad Maternity Unit at Central District Hospital	August-December 2012: 0		January-June 2014: 8	Missing data for 2013

Sources: Interviews, MoH, UNFPA

Recognizing that it is still early days, the under-utilization of the VSRs can be ascribed to two main factors. On the one hand, the deeply engrained gender stereotypes and cultural norms that prevent women from seeking external help. One RH group discussion participant paraphrased domestic violence as “a family secret”. On the other hand the above-mentioned insufficient knowledge about the VSRs among institutional partners and women. Moreover, when asked, numerous health

personnel dealing with women and youth on a daily basis, such as in district RHCs and maternity hospitals, potential "trust points" according to one interviewee, felt insufficiently qualified to approach and refer victims of violence. The evaluation team was informed by various interviewees that neither pre-service education nor in-service training curricula for sexual and reproductive health include GBV-related courses.

Finding 37: The recently signed MoH victim support room order and regulation - drafted by UNFPA - is an important step for institutionalizing VSRs in Tajikistan, including ensuring a consistent and uniform set of quality services and improving the availability of reliable statistics, as well as for promoting the use of and referral to VSRs.

To formalize the VSRs and ensure unified workflows and reliable data, in 2012/2013, UNFPA drafted regulation for the VSRs, including two attachments - i.e., instructions on interventions of medical workers in cases of family violence and the GBV registration card. The package was submitted for approval to the MoH. According to UNFPA records, 16 health professionals in charge of the VSRs were trained in 2013 to pilot the GBV registration cards. However, they were not being used in the visited VSRs. During the CPE field mission, on 25 June 2014, the MoHSP signed the VSR order and regulation. Interviewees considered this act crucial for ensuring consistent and professional client-centred care and advice, focused on privacy and confidentiality as well as the clients' dignity, safety and right to taking an informed decision. Thanks to the GBV registration cards, interviewed stakeholders expected an improvement in the availability and reliability of data on women victims of violence. It was also considered key for informing about and promoting VSRs among women and vulnerable groups of women as well as among institutional partners as part of referral systems.

Finding 38: Support for two state facilities in Dushanbe outside the health sector has not produced expected results. While one shelter has not yet been established, the other is under-utilized.

In addition to the eight VSRs, in 2012 and 2013 respectively, UNFPA supported the Dushanbe State Women Centre and the CWFA Girls Support Centre with equipment and capacity building activities[105] to establish and manage temporary rooms for women victims of violence. The evaluation team visited both locations where interviewed staff highly appreciated support provided. Contrary to the above-discussed VSRs, both institutions work outside the health sector, and it is unclear whether the new MoHSP VSR regulation applies.

According to interviewees, the State Women Centre has only just found an appropriate building for its shelter, intended to be the first specialized long-term facility in Dushanbe for women victims of violence and their children. Equipment provided by UNFPA in 2012, including an ultrasound machine[106], remains unpacked. Stakeholders anticipate the imminent approval of the Mayor of Dushanbe of the envisaged building and expect the shelter to be fully functioning, funded through the municipal budget, by early 2015. The CWFA Girls Support Centre offers support services in a large multi-storey building on the outskirts of Dushanbe for different female clients - i.e., for orphaned girl students, for girl victims of sexual violence[107] and - most recently - for women victims of violence. The UNFPA-supported temporary shelter for women victims of violence at the CWFA Girls Support Centre is the largest visited VSR, catering for more than ten women at a time. Yet, the evaluation team was informed that only five clients had stayed overnight, four of which with children, since its opening in late 2013; two to three women a week make use of the telephone hotline. Assuming that the number of women victims of violence seeking shelter will grow once the

[105] According to UNFPA records, 6-day internship at the Anna National Centre for the Prevention of Violence in Moscow in 2012 for State Women Centre staff members and attendance of its Director at the World Shelter Conference in Washington DC; 3-day on-the-job training for CWFA Girls Support Centre staff members in 2013.
[106] It remains unclear to the evaluation team why UNFPA procured an ultrasound machine in this particular case of a shelter operating outside the health sector (none were procured for any of the VSRs discussed above).
[107] Supported by UNICEF.

VSR is better known, the question was raised on more than one occasion as to whether the Centre disposed of sufficient human resource capacity to exercise due diligence in caring for the different categories of clients, each one of which finds herself in a difficult - and different - situation.

EQ3g: To what extent has UNFPA strengthened capacities and awareness of state and civil society actors on gender inequalities, contributing to efforts to transform discriminatory social norms?

Outside the immediate context of the VSRs, UNFPA has supported and brought together a row of non-health state actors - the CWFA, parliamentarians, the Office of the Human Rights Ombudsman the Religious Affairs Committee and local NGOs - to understand, respect and promote women's rights in their own settings. Along with other international development actors such as UN Women, UNICEF, SDC/PDV and the OSCE as well as local women's and human rights organizations, UNFPA has achieved some important accomplishments, but only gradual change. Gender stereotypes and discriminatory social norms still prevail in Tajikistan.

Finding 39: Also thanks to UNFPA, the Government of RT is better able to adhere to its reporting commitments under international human rights treaties (CEDAW and UPR).

UNFPA has supported the adherence of the Government of RT to its international reporting commitments in the area of GE. As state party to CEDAW, the government is required to provide periodic reports. Upon a reminder from the Secretariat in March 2011, Tajikistan submitted its combined 4th and 5th periodic reports to the CEDAW Committee 56th session in October 2013 describing measures taken between 2006 and 2010 to implement the provisions of CEDAW.[108] This process benefitted from UNFPA inputs[109] and support, including a two-day mock session organized by UN agencies and SDC/PDV to help prepare the government delegation to present its report and engage in dialogue with the CEDAW Committee. In April 2014, UNFPA co-initiated an event with experts and members of the national working groups on CEDAW and the UPR, which identified synergies between the two processes.

Finding 40: UNFPA has promoted the enforcement of the increased minimum legal age of marriage, which remains a concern in parts of Tajikistan.

UNFPA has also contributed to national policies that respond to the needs of Tajik women. In 2012, following the 2010 amendment to the Tajikistan Family Code and the Criminal Code to change the legal marriage age from 17 to 18 years of age in adherence to the CRC and as part of the EECARO Regional Survey on Early Marriages, UNFPA produced a Factsheet on Child Marriages in Tajikistan. Qualitative research found that this harmful practice is not common to the same extent in all parts of Tajikistan, that it is driven by religious misinterpretation, tradition and economic factors, such as poverty and labour migration, and that there had been little change in the number of young people in child marriages between 2000 and 2010. In October 2012, on the occasion of the 1st International Day of the Girl Child in 2012, UNFPA co-hosted activities and discussions to raise further awareness about early marriage and the issues young women face. Today, while there were some are optimistic views, interviews and documentary analysis illustrate that the amended legislation is not yet strictly enforced and that early and unregistered marriages, particularly in rural areas, remain a common phenomenon in Tajikistan. The Government of RT has addressed the ensuing tendency for families to resort to unmonitored religious marriages by obliging Muslim clerics to require a certificate of civil marriage registration before conducting religious wedding ceremonies. However, this requirement is reportedly not always enforced.[110] The evaluation team also heard that a growing number of

[108] CEDAW/C/TJK/4-5 dated 22 March 2012.
[109] Paragraph 79 explicitly mentions the VSRs.
[110] See also United States Department of State, Bureau of Democracy, Human Rights and Labour, Country Reports on Human Rights Practices for 2012, Tajikistan 2012 Human Rights Report.

divorces were linked to the phenomenon of early marriages. One interviewee spoke of a growing trend towards equally harmful early engagements as a consequence of the amended legislation.

Finding 41: UNFPA has facilitated national recommendations to improve the gender-sensitivity of the Tajik justice system, but no structured follow-up has taken place.

Women, and especially rural women, have limited access to justice in Tajikistan. In 2012, together with the CWFA, UNFPA commissioned the NGO League of Women Lawyers to research the gender sensitivity of judges in selected districts. The study, the first of its kind, was subsequently presented at a roundtable event where participants[111] reportedly developed a set of recommendations to address the overall finding that judges were prejudiced and prone to holding gender-based stereotypes. To the best of the evaluation team's knowledge, there has been no systematic follow-up on the recommendations. In this connection, it did however note the CEDAW Committee's recommendation to the Government of RT in 2013 to provide mandatory training for judges, prosecutors and police officers on the strict application of legal provisions criminalizing violence against women.

Finding 42: UNFPA was instrumental in formulating Tajikistan's first domestic violence law and action plan, which has, however, experienced a slow start. Together with UNICEF and WHO, it also successfully promoted gender-sensitive amendments to the 2002 Law on Reproductive Health. Work with parliament has secured a commitment to screen laws from a gender perspective.

Domestic violence is the most pervasive form of VAW in Tajikistan. UNFPA, along with numerous other international and national organizations, is recognized to have contributed to the development of the first Law on Prevention of Violence in the Family. The Law was finally adopted in March 2013 after a decade of lobbying and preparatory work, followed by the adoption of a State Programme and Action Plan to Prevent Domestic Violence for 2014-2023. Interviewees, both governmental and non-governmental, recognized this new legal framework as a good starting point for coordinating and strengthening efforts to address widespread domestic violence despite some weaknesses in design and a slow start to its implementation. They particularly underlined that roles and responsibilities remained unclear, the public remained unaware of the law, monitoring mechanisms are lacking, and funding is insufficient. UNFPA's particular contribution to implementing the new law are the VSRs discussed above. Furthermore, as part of its Joint Work Plan with UNICEF and WHO, UNFPA successfully promoted gender-sensitive amendments to the 2002 Law on Reproductive Health and Rights. The adoption of the revised law is expected in late 2014. In this connection, the evaluation team was informed of the intention of the Committee on Social, Family and Healthcare Issues of the Lower House of Parliament to screen and revise existing and draft laws from a gender perspective. Given that parliamentary elections are scheduled for 2015, the execution of this plan remains to be seen.

Finding 43: Broad-based support, including from UNFPA, has not yet resulted in an Ombudsman Office that champions women's rights, despite the strategic intent of the institution.

UNFPA has worked with newly-created state agencies to promote GE and women's empowerment. In 2009, Tajikistan established the Office of the Human Rights Ombudsman responsible for improving Tajik human rights. According to the Ombudsman Office Strategy 2011-2015, one of its strategic priorities is to promote the protection of particularly vulnerable groups such as women, children and persons with disabilities, with a strong focus on children. The work of the Ombudsman Office is supported by an array of development actors, including the OSCE, the Danish Institute for Human Rights and UN agencies. As part of the UN Joint Programme to Support the Ombudsman Office 2010-2012, UNFPA provided trainings, study tours and organized public receptions in selected districts to familiarize Ombudsman Office staff with the ICPD and to enhance its capacities to

[111] According to UNFPA records, including parliamentarians and representatives of the Ombudsman office, courts, prosecutor's office, CWFA, Statistical Agency as well as international and local organizations.

advance women's rights with a focus on reproductive rights and the rights of women living with HIV. Ombudsman Office staff located in the regions also attended information sessions around the opening of the VSRs in maternity hospitals. According to interviewees in Khatlon and Soghd regions, however, the Ombudsman Office, while responsive to ideas and requests, has a lower profile than other state agencies in the area of GE and VAW, both at the level of policy and of individuals. This realization is corroborated by the finding of the US State Department[112] that the Ombudsman Office had made very little effort to respond to complaints during 2012 and 2013, and that its limited staff and budget further constrained its capacity to do so. According to replies of the Tajik delegation to the list of issues in connection with the consideration of its combined fourth and fifth periodic reports, no written appeals pertaining to violence or discrimination against women had been filed with the Ombudsman Office in 2009-2012.

Finding 44: Collaboration with the Religious Affairs Committee to involve religious leaders in reducing gender stereotypes and harmful practices is work in progress with great potential.

UNFPA-Religious Affairs Committee Banner

In 2010, Tajikistan reinstated the Religious Affairs Committee to oversee the country's religious laws and organizations. Since then, UNFPA, allegedly with explicit support of the President of RT, has been the Committee's main international partner, including in the area of GE.[113] According to UNFPA records, UNFPA and the Committee, in collaboration with the Centre for Islamic Studies within the President's Executive Office, trained 60 religious leaders on gender and the influence of gender relations in the family and the society. UNFPA also contributed to the development of gender equality-related guidance for religious leaders from the perspective of Islam, including sermons for Friday prayers, which time and again was positively referred to in different interview settings. Given that active observance of Islam, especially among youth, seems to be increasing, interviewees widely agreed that religious leaders have great potential for engaging communities and in particular (young) men to decrease gender stereotypes.[114] Several emphasized the importance of working with female religious leaders to approach women in more intimate situations. However, changing generally conservative attitudes and behaviours on the part of religious leaders was acknowledged to require more knowledge transfer and continuous engagement. To this intent, UNFPA is involved in negotiations to establish a faculty for continued education of religious leaders on ICPD within the Islamic Centre.

Finding 45: Lack of a monitoring system does not allow an assessment of efforts to transform discriminatory social norms resulting from Stepping Stones training for Tajik NGOs.

UNFPA has also supported local NGOs to transform gender relations. In 2012, with the assistance of the Kyrgyz Family Planning Alliance, UNFPA introduced the Stepping Stones[115] training package to selected NGOs. Since no system was set up to monitor training follow-up, the evaluation team was unable to evaluate benefits emanating from this intervention and the number of communities or individuals ultimately reached by the trained NGOs. However, interviewed training beneficiaries expressed their appreciation for support provided and claimed to be still using Stepping Stones modules. Apart from the local NGO Gender and Development, which became an Implementing Partner in 2013, beneficiaries regretted the one-time nature of their collaboration with UNFPA.

[112] United States Department of State, Bureau of Democracy, Human Rights and Labour, Tajikistan Human Rights Reports 2012 and 2013.
[113] Since 2012, the Religious Affairs Committee is UNFPA Implementing Partner in the area of HIV prevention.
[114] The June 2012 UNDP/UNFPA Executive Board delegation to Tajikistan encouraged UNFPA to continue establishing a wide and inclusive dialogue with religious leaders in the area of GE.
[115] http://www.steppingstonesfeedback.org/.

Joint Women's Empowerment Photo Exhibition Dushanbe

Gender and Development has since, on behalf of UNFPA, conducted further Stepping Stones trainings for local NGOs and community representatives - i.e., in the context of UNFPA's involvement in the UNCT Joint Programme Empowering Communities with Better Livelihoods and Social Protection in the Rasht Valley 2013-2016.

Finding 46: Under the UN Secretary-General's UNiTE Campaign, including with the support of UNFPA, the National Taekwondo Federation has successfully created its own social movement for gender equality and the empowerment of women and girls.

Stepping Stones training was also used to raise awareness and build the capacities of the 2013-established Men-led Network against Violence of five national sports federations, initiated by the National Taekwondo Federation, with whom UNFPA and other UN agencies have been working since 2010 under the UN Secretary-General's UNiTE Campaign to End Violence against Women. While the network is still young, the National Taekwondo Federation has successfully created its own social movement for engaging men and boys to promote gender equality and for empowering women and girls, both in Tajikistan and when travelling abroad.[116] Its founder and president is a member of the UN Secretary-General's Network of Men Leaders.[117] In light of this, UNFPA has already started to scale down its financial and logistical support. For the future, interviewees agreed that continued expert advice on GE and ICPD-related matters would continue to be valuable.

4.2.7 Development Partnerships

This section examines the extent to which UNFPA has leveraged partnerships to achieve its objectives. It focuses on the CO's intentions, actions and experience. External views on the added value of partnering with UNFPA are assessed under the evaluation criteria "strategic positioning".

EQ4: To what extent has the UNFPA country office successfully used partnerships with other development actors to achieve its objectives?

Finding 47: UNFPA has made good on its intentions to collaborate closely with other development actors as expressed in the CPD and CPAP. UNFPA's partners are most often sister UN agencies.

According to the Tajikistan CPD, UNFPA will collaborate with bilateral and multilateral partners, including the European Union, GFATM, UNAIDS, UNICEF, UNDP, UNIFEM, WHO and other development partners. According to the CPAP, a synergetic approach with internal and external stakeholders will be used to achieve the interlinked and prioritized goals. Besides working with the Government of RT, the CO planned to closely collaborate with other UN and international aid agencies, specifically IPPF, WHO, GFATM, UNAIDS and the Finnish Government. UNFPA will pursue joining efforts with other UN partners within the framework of UNDAF as a major partnership strategy. It will work with relevant UN agencies to develop joint programmes/programming in the areas where coordinating efforts can bring maximum results in achieving national development goals. The potential areas for joint programme include improving quality of maternal health care, improving in-school education on reproductive health, increasing access to quality information on maternal and reproductive health , educating adolescents on healthy lifestyle issues, HIV prevention and empowerment of women. Specific joint programming efforts within the next

[116] In June 2013, the UNDP/UNFPA Executive Board delegation to Tajikistan was impressed by UNFPA's partnership with the National Taekwondo Federation to address GBV and empower girls through participation in sports events. See also Harmony of Body and Spirit, National Taekwondo Federation, 2012, for examples of UNFPA-National Taekwondo Federation Joint Activities.

[117] http://www.un.org/en/women/endviolence/MirsaidYakhyaev.shtml.

programme cycle included i) joint programming with UNAIDS, UNDP and UNICEF on Advocacy on HIV; ii) joint programming with WHO in areas such as family planning, safe motherhood, maternal audit, safe abortion, reviewing the Law on RH.

UNFPA has made good on its intentions as expressed in the CPD and CPAP. According to information received[118], it has made considerable use of partnerships to achieve its objectives. In the area of RH, it has been involved in ten partnerships, seven of which were ongoing at the time of the CPE. In GE, UNFPA has participated in four partnerships, two of which ongoing. In PD, UNFPA has entered into four partnerships, two of which ongoing. Partnerships are not "one-off" in nature: The average duration of a partnership ranges from two and a half years for PD to nearly three years in RH and three and a half years in GE. The most recent partnership was entered into in 2014 - i.e., the 2nd joint annual work plan with WHO and UNICEF in the area of maternal and reproductive health.

Not only the number and duration of partnerships are indicators for UNFPA's successful use of partnerships to achieve its objectives, but also the amount of parallel funding mobilized, in this case a considerable $1,796,116 between 2010 and May 2014 (table 13).

According to the partnership mapping, UNFPA's partners are most often sister UN agencies. In the area of RH, the main partners are UNICEF, UNDP, WHO and UNAIDS; in GE, mainly UN Women (formerly UNIFEM) and UNDP; in PD both UNDP and UNICEF at the country level. Present-day non-UNCT partners are GIZ (MH), USAID (MH, FP and PD) and Mercy Corps (FP). The only gap between plan and practice is as regards UNFPA's plans to collaborate with the European Union and the Finnish Government. The basis for collaboration differs. It ranges from informal ad hoc collaboration on specific issues, a more formal Memorandum of Understanding (MoU) or a joint Annual Work Plan (AWP) to a formal multi-year and multi-stakeholder Joint Programme with varying fund management modalities.

Finding 48: UNFPA CO interviewees clearly agree with the hypothesis that partnerships accelerate progress towards the Fund's objectives in Tajikistan. Benefits mentioned are money savings, access to new funding sources, programmatic synergies and opportunities to expand pilots.

UNFPA CO interviewees clearly agree with the hypothesis that partnerships with other development actors accelerate progress towards UNFPA's objectives. Benefits mentioned are:

- money savings through parallel funding;
- access to new funding sources such as in the case of UN Trust Fund for Human Security (UNTFHS);
- programmatic synergies such as thanks to collaboration with UNICEF on the censusinfo database, which has allowed access to census and social indicators in one place, or thanks to collaboration with USAID on the DHS, which allowed for coverage of both medical and population issues; and
- opportunities to expand pilots - e.g., the expansion of UNFPA-supported guidance for midwifes on EmOC provision by USAID and GIZ in selected districts.

4.3. EFFICIENCY

This chapter discusses the efficiency of UNFPA's 3rd CP. Efficiency is defined as the extent to which the CO has made good use of its financial and human resources for delivering results.

[118] As part of the CPE, the UNFPA CO provided the evaluation team with a mapping of key development partnerships (annex 9), listing 18 partnerships since 2010. To this intent, "partnerships" was defined as arrangements in which two or more development partners agree to cooperate to advance their mutual interests and achieve their objectives. Not included in the definition were loose forms of working groups or coordination bodies for the main purpose of information exchange. Neither was it applied to government entities, donors or contractors receiving financial assistance from UNFPA for implementing specific activities.

EQ6: To what extent has the UNFPA country office made good use of its financial and human resources to implement the country programme?

4.3.1 Use of Financial Resources

Finding 49: UNFPA headquarters has made Regular Resources available to the extent planned. The CO has implemented the initial plan to emphasize RH followed by PD and GE. However, this financial picture masks the fact that GE and HIV prevention have received greater attention than originally envisaged; MH and FP have seen significant funding reductions.

As shown in tables 8 and 9 above, UNFPA HQ has provided the Tajikistan CO with a total of $4,486,441 for the time period 2010 to 2014. This corresponds to 82% of planned RR, the extent that could be expected given a six-year programme cycle.[119] At the level of the CO, RR were distributed among the six projects based on annual expenditure projections included in annual work plans (AWPs). Noticeable is that

- HIV prevention only began receiving RR in 2011 - in 2010 activities were funded entirely by UNDP/GFATM;
- Since 2011, RR allocations for HIV have steadily increased from $86,677 to $141,379;
- Total RR allocations to GE to date are already 160% of planned RR ($640,888 as compared to $400,000);
- RR allocations for MH (from $352,909 to $154,896) and FP (from $266,510 to $130,811) have significantly declined to around half the 2010 amounts;
- PD was at its financial height in 2010 in connection with the Population and Housing Census.

As stated by stakeholders, the steady increase in RR for HIV prevention has been to mirror growing funds received from UNDP/GFATM; it has been crucial for receiving continued funding. According to information received from the CO, the prominent increase in RR allocations for GE was due to a deteriorating situation of women, a number of incomplete ongoing activities, requests from participants in annual review meetings, efforts to mainstream gender in the other programmatic areas, and less OR than envisaged.

Finding 50: Only 57% of planned Other Resources have been mobilized, mainly thanks to HIV prevention among key populations. Nevertheless, while OR are below target, total annual resources have continually grown since 2011, and the outlook is positive due to the arrival on the scene of new donors and parallel funding.

As shown in tables 10 and 11 above, UNFPA has only succeeded in raising 57% of planned OR. That said, after an initial dip in 2011, the amount of OR climbed to around $100,000 in 2012 and 2013/2014 saw a considerable jump to over $700,000. The RH programmatic area was most successful, both in absolute and percentage terms. It has attracted 77% of planned OR - i.e., $1,926,883, of which $1,389,797 for HIV prevention. Despite initial expectations, no OR have been raised for PD so far; some $30,000 (or 6% of planned OR) have been received for GE.[120]

New donors have started contributing to the UNFPA Tajikistan CP. Funds have been received from UNDP/GFATM for HIV prevention, from RusAid for HIV-related activities[121] implemented under the MH, FP and ASRH projects, from the Global Programme Reproductive Health Commodities Security (GPRHCS)[122] for FP and from the UNTFHS for MH, FP, PD and GE[123]. At the time of the evaluation field mission, fundraising efforts were ongoing to secure further funding from RusAid for RH and PD.

[119] Based on an average yearly allocation of 16.7% of total RR.
[120] From EECARO in 2012 and the UNTFHS in 2014.
[121] Technical Assistance Programme for Countries of Eastern Europe and Central Asia in Combating Infectious Diseases, implemented through UNAIDS since 2013 (http://www.rusaid.ru/?page_id=658&lang=en).
[122] http://www.unfpa.org/public/supplies/pid/3591.

Total annual resources (RR and OR) have continually grown, after a dip in 2011, thanks mainly to considerable OR for HIV prevention. On average, available funding has been at a level of nearly $1.3m a year; including annual project budgets of some $367,660 for HIV prevention, $256,870 for FP, $214,360 for MH, $150,660 for PD, $134,080 for GE and $111,370 for ASRH.

Finding 51: 2010 to 2013 saw very high financial project implementation rates for all projects. Interviewed beneficiaries feel they have received value for money.

A key aspect of efficiency is the profile of expenditure relative to available funds. Leaving funds unspent might represent a lost opportunity and is potentially a waste of resources. 2010 to 2013 saw a very high financial project implementation rate for all projects (table 20).

Table 20: Project Implementation Rate 2010-2013 (2014[124])

	2010	2011	2012	2013	(2014)
FP	96.00%	97.03%	99.90%	98.20%	45.60%
MH	88.23%	99.15%	99.70%	98.90%	30.60%
ASRH	100.02%	97.89%	99.20%	99.00%	39.80%
HIV	100.00%	97.93%	98.50%	97.00%	32.30%
GE	99.85%	99.81%	99.80%	98.30%	41.40%
PD	99.97%	94.80%	99.30%	99.10%	39.60%

Source: Atlas Project Monitoring

The evaluation team has no evidence of any critical delays on the part of UNFPA in delivering products and services under its control. To the extent it can assess, all medical commodities and supplies were provided to the MoH and distributed among RH institutions as per existing procedures, rules and needs. Interviewees generally valued UNFPA's timeliness. No interviewees voicing an opinion were aware of any inefficiency in terms of scope for delivering products and services with fewer resources without reducing their quality and quantity.

Finding 52: NEX is an important aspect of country programme implementation in Tajikistan. It helps to reduce the administrative burden on CO staff and to increase national ownership. IPs have been subject to external financial audits in compliance with UNFPA rules and regulations. While some management control weaknesses were detected, audits confirmed that UNFPA project funds had been used in conformity with contractual arrangements.

With NEX, UNFPA entrusts resources to governmental and non-governmental IPs to undertake and manage AWPs. Over the programme cycle, UNFPA Tajikistan increased the number of its IPs to ten and the amount of funds expended through NEX to a total of $1,167,073 (table 17), around 20% of total expenditures over the same period, and reportedly one of the highest NEX portfolios in the region. All projects were partially implemented by both governmental and non-governmental IPs applying the NEX modality. The largest in financial terms - i.e., HIV prevention - was co-implemented by two government entities and three NGOs. While associated with investments in time and money for training IPs in NEX, sometimes more than once due to staff rotation - e.g., anticipated for CWFA in 2014 - UNFPA CO staff members consider NEX the preferred modality as compared to direct execution (DEX), helping to reduce the administrative burden on technical staff. While IPs did not consider NEX particularly complicated, some mentioned the difficulty of providing certain required supporting documentation/evidence for the recovery of expenses, particularly in rural areas - e.g., for travel of training participants. Interviewees generally expressed the feeling that NEX increases national ownership for UNFPA's CP.

The expense of UNFPA funds by an IP must be externally audited each year that the total expense incurred is equal or greater than $100,000 and at least once in the programme cycle. The CO shared

[123] Including commitments for 2015 and 2016.
[124] As of 5 August 2014.

six audit reports with the evaluation team.[125] Based on information presented in table 17, the CO has thus far complied with UNFPA rules and regulations. By the end of the current programme cycle, it will at least need to audit the remaining IPs - i.e., Statistical Agency, Religious Committee and the two NGOs Gender and Development and Tajik Family Planning Alliance. In all cases, the auditor found "project funding provided by UNFPA, in all material aspects, to have been used in conformity with applicable contractual conditions". Without qualifying this opinion, the auditor detected important management control weaknesses - i.e., support costs incorrectly calculated followed by insufficient/no supporting documentation, excessive use of cash payments (2011/2012), and no competitive procedures for the award of contracts.

Finding 53: AWPs have undergone regular, but justifiable, changes most often resulting in higher annual budgets.

AWPs and their respective budgets underwent a number of revisions during implementation (annex 6). Most often, budgets were increased during the year to accommodate new or more of the same activities, to cover higher than planned costs, and thanks to new OR. Sizeable changes were made to MH, FP and HIV prevention. The largest increases were in HIV prevention in 2013 (+$196,799) thanks to new UNDP/GFATM funding and in MH in 2010 (+$130,265) to fund additional EPC activities, establish EmOC services and to pay for higher IEC costs. Only few activities were scaled back, cancelled or postponed, leading to budget decreases, particularly in PD and GE. All in all, and based on the level of information available, the evaluation team considers justifications for changes to AWPs reasonable.

Finding 54: Administrative costs accruing to UNFPA for implementing the CP are on the high side, amounting to a third of all expenditures between 2010 and 2013.

Project support costs, funded through UNFPA RR, encompass the costs of programme staff as well as other costs such as for premises, drivers and office supplies. They accrue to the UNFPA CO in addition to Programme Coordination and Assistance (PCA) and BSB expenditures, and are allocated to each AWP on a pro-rata basis irrespective of project budgets or expenses.

Table 21 depicts actual project support costs for 2010 to 2013 in absolute terms per project and overall.[126] There is no known ceiling for project support costs and the evaluation team is unable to make comparisons with other UNFPA COs. Generally speaking, it is acknowledged that there is no one-size-fits-all structure; however, it would seem that they are on the high side. From table 21, it is evident that actual project support costs have constantly grown over the period under evaluation, from $239,409 in 2010 to $341,148 in 2013 (and $411,036 planned for 2014). Over the 2010-2013 period they amount to $1,137,773. Together with PCA and BSB expenditures of $648,016 (table 16), overhead costs accruing to the UNFPA CO for 2010 to 2013 amounted to $1,785,789. This equals a third (34.6%) of all expenditures (RR and OR) for the same period[127].

Table 21: Project Support Costs in USD 2010-2013 (2014[128])

	2010	2011	2012	2013	(2014)
FP	49,794	47,023	56,326	58,776	64,845
MH	59,695	44,891	56,260	56,262	56,841
HIV prevention	20,198	30,972	42,400	68,637	125,815
ASRH	52,001	34,121	42,652	46,886	57,870
PD	33,159	50,282	62,858	63,401	51,185
GE	24,562	42,378	47,053	47,186	54,480

[125] MoH 2011; CWFA 2012; Youth Committee 2012; Antispid 2013; Apiron 2013 and Fidokor 2013.
[126] It was outside the scope of the present evaluation to enquire into the detailed composition of project support costs.
[127] Total expenditures 2010-2013: $5,155,704.
[128] Planned.

Total	**239,409**	**249,667**	**307,549**	**341,148**	**411,036**

Source: Atlas Project Monitoring

4.3.2 Use of Human Resources

Finding 55: The current setup for managing and supervising the CO is challenging because of three management layers, the involvement of UNDP, geographical distance and competing priorities.

The UNFPA CO in Tajikistan is managed by an Assistant Representative (AR) under the supervision of the UNFPA Country Director (CD) based in Tashkent, Uzbekistan. The CD is simultaneously responsible for Uzbekistan and Turkmenistan. As per a corporate Memorandum of Understanding (MoU) between UNFPA and UNDP, the UNDP Representative/UN Resident Coordinator in Tajikistan is the UNFPA Representative. Neither the AR, nor the CD nor the UNDP RR had taken up their positions at the time the current CP was designed and approved.

Interviewees expressing a view generally consider this organizational set up a challenge, although one that is manageable thanks to good personal relationships and - according to one interviewee - "intuition". One area for improvement suggested is the above-mentioned corporate MoU between UNFPA and UNDP that is apparently outdated; linked to this is the lack of an induction briefing/orientation for UNDP staff when taking up their positions as UNFPA Representatives. A second area of concern is the physical distance between Tashkent and Dushanbe, which can be somewhat overcome thanks to modern means of communication, and the CD's limited time availability due to competing commitments.

Finding 56: Partner views were predominantly positive when talking about the appropriateness of human resources to implement the UNFPA CP. Within the CO, ideas exist for improving office performance revolving around re-structuring and additional staff.

Besides the AR, the UNFPA CO consists of five staff members with fixed term agreements - i.e., two NPOs, one admin/finance associate, one secretary and one driver - and nine service contractors. As its organigram (annex 7) depicts, the CO is staffed with two NPOs on PD and on RH. While the NPO on RH manages the MH project, FP and ASRH are each managed by a National Project Associate (NPA) under her supervision. The fourth RH-related project on HIV prevention is managed independently by a NPA with the support of a dedicated M&E expert and admin/finance assistant. While the organigram envisages the recruitment of a NPO HIV/AIDS, at the time of the field mission, a capacity-building specialist for key populations had started work. GE is managed by a NPA under the NPO on PD. All but one technical expert (NPO on PD) have been with UNFPA since the beginning of the current programme cycle in 2010. The NPO on PD is simultaneously the CO M&E focal point; the NPA on ASRH the CO communication focal point. An admin/finance associate, together with an assistant, is in charge of finance and administration. A secretary, two drivers and a cleaner support the running of the CO and UNFPA projects. The current organigram does not differ greatly from the September 2010 approved organigram. In 2014, the NPA on GE post was moved under the NPO on PD. In the course of 2013/2014, the HIV project team has grown from one NPA to one NPA, a capacity-building expert, one M&E expert and a project admin/finance.

While outside views were predominantly positive when talking about the competences and accessibility of UNFPA CO staff, reflecting no need for change, few interviewees more familiar with the office set-up provided the evaluation team with their ideas on how to improve performance. Individual suggestions included:

- Explore different structure/division of labour in connection with new CP;
- Introduce national head of office;
- De-link GE from PD;
- Recruit an assistant for MH given its size and importance;
- Recruit additional staff for the 2020 census;
- Recruit a dedicated communications person;
- Recruit a designated M&E officer; and

- Strengthen CO capacities on emergencies.

4.4. SUSTAINABILITY

This chapter discusses the potential sustainability of UNFPA's 3rd CP. Sustainability is defined as the continuation of benefits from UNFPA-financed interventions, linked, in particular, to their resilience to risks.

EQ7: To what extent has the UNFPA country office identified and addressed factors and conditions affecting the sustainability of UNFPA-supported results?

Finding 57: Sustainability is a weak aspect of the CO's planning, monitoring and reporting.

The CPAP lists the major "challenges" that were encountered during the implementation of the 2nd CP, and which were considered to have the potential to further impede the achievement of UNFPA's contribution to ICPD/MDG goals in Tajikistan, without any further substantiation:

- low level of public and government administration and weak judicial and law enforcement systems;
- weak capacity of governmental stakeholders, especially in policy and decision-making processes;
- economic crisis that is influencing resources of international aid agencies;
- unequal access to and inappropriate distribution of financial resources due to ongoing restructuring of health care institutions;
- continued food insecurity;
- extreme weather conditions;
- unreliable national electricity, natural gas and heating supply system;
- low utilization of family planning services due to deep-rooted taboos;
- political discussions of the Russian Federation to reduce by 50% the number of labour migrants; and
- the country's weak political and economic leverages in trans-boundary relations with neighbouring countries.

The CPAP Results and Resource Framework does not include any risks and assumptions - i.e., hypotheses on external factors that could positively or negatively affect the success of UNFPA's interventions and the likelihood that benefits continue and eventually contribute to high-level impact. In 2011, the CPAP Planning and Tracking Tool (CPAP PTT) identified a number of risks and assumptions for RH, PD and GE respectively. However, the evaluation team finds that they are not well reasoned. They do not pick up on the above-mentioned "challenges". In some instances, risks are included under the assumption category - e.g., "weak capacity of partners to implement NEX"; they are not external to UNFPA - e.g., "UNFPA materials are developed"; and risks and assumptions neutralize each other - e.g., "there will be sustained political will" versus "lack of political will". Risks and assumptions are not picked up in Annual Work Plans (AWPs) or discussed in Standard Progress Reports (SPRs). There have been no noteworthy modifications, not even at the time of the early-2012 alignment exercise.

While not excluding the existence of others, the evaluation team has identified[129] four factors and conditions with great potential to affect the extent to which enhanced country capacity will effectively lead to sustainable change, which are discussed in more depth below:

- Political commitment and institutional capacities;
- UNFPA corporate priorities;

[129] Based on the CPAP, the CPAP Results and Resource Framework and interviews conducted.

- Domestic resources and the future of financial aid; and
- Human security situation.

Finding 58: UNFPA has succeeded in building political commitment and institutional capacities and thus creating an enabling environment for stakeholders to sustain programme benefits. There are some political risks to its work with HIV key populations.

UNFPA's work in Tajikistan relies on the continued commitment and will of Tajikistan's state branches to collaborate with UNFPA and to use improved skills and capabilities to incorporate and advance the ICPD and MDG/SDG agendas. Generally speaking, UNFPA has paid attention to government ownership by way of using the NEX modality, by promoting, facilitating and supporting national laws, policies, programmes and standards and by building institutional capacity.

Stakeholders from both the education and health sectors that were interviewed confirmed enhanced capacities in MH, FP and ASRH in terms of new knowledge and skills and equipment to apply modern approaches. This, alongside personal motivation in many instances, was also observed by the evaluation team. Moreover, new and revised medical education programmes (e.g., basic, continuing and midwifery education) have been adapted to local conditions and integrated into official health curricula. On the other hand, as seen above, the Ministry of Interior's behaviour towards SWs and MSM, key UNFPA beneficiaries, is ambivalent, putting a question mark over UNFPA's and its partner NGOs' future engagement with these population groups at risk and threatening accomplishments achieved so far.

In the area of GE, most key representatives of the executive and legislative Tajikistan state branches interviewed by the evaluation team expressed their keenness to improve the situation of women; they are supported and prompted in this quest by active women and human rights organizations with whom UNFPA collaborates. Stakeholders consider the fairly recent CEDAW and UPR recommendations and the first Law on Prevention of Violence in the Family to provide important building blocks for further efforts. In the health sector and as regards VAW[130], interviews revealed that trainings on GBV for selected health facility personnel have not had a lasting effect in terms of knowledge sharing and broader attention being paid to women victims of violence. On the other hand, the very recent signature of the Minister of Health formalizing the UNFPA-supported victim support rooms (VSRs) greatly enhances their institutional sustainability prospects and the potential of them being rolled out in future.

As regards PD, interviewed government stakeholders at national and regional level confirmed increased knowledge and capacities in population registration and data management and interest in further collaboration on population dynamics and policy - e.g., on migration data collection and analysis. They clearly value and own newly-established inter-ministerial working relationships.

Finding 59: For the near future, UNFPA corporate priorities are conducive to sustaining and building on the CO's results. The Strategic Plan 2014-2017 provides room for intensifying investments in young people as part of the UNFPA Tajikistan 4th country programme.

Sustainability of activities undertaken and results achieved over the present programme cycle also depend upon the priorities set by UNFPA and the Government of RT remaining UNFPA corporate priorities as approved by the UNDP/UNFPA Executive Board. As seen under the relevance evaluation criteria, all current programmatic areas and key beneficiaries remain directly relevant to UNFPA's Strategic Plan 2014-2017 and its four outcome areas, allowing for some predictability in term of the CO's engagement and medium-term planning. It is worth noting here that the 2014-2017 SP provides for intensified efforts to prioritize and invest in young people and their sexual and

[130] In this context, the evaluation team would also like to draw attention to the May 2014 WHO resolution "Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children" as a potential impact driver. The resolution urges member states, including Tajikistan, to ensure that all people affected by violence have timely, effective and affordable access to health services.

reproductive health (including HIV) education and services.

Finding 60: Domestic resources for the social sectors remain scarce, rendering ODA and resource mobilization all the more important for maintaining and leveraging UNFPA-supported results. The uncertain future of GFATM in Tajikistan is of utmost importance for continuing and sustaining UNFPA's work in HIV prevention as part of the UNFPA Tajikistan 4th country programme.

Numerous interviewees confirmed that the Government of RT is strapped for cash, that the state budget is highly dependent on remittances, and that it faces competing needs and interests. The country is also dependent on external funding, which, in a globally unfavourable budget environment, has fortunately remained stable over recent years.[131] Financing for health and HIV is particularly dependent on external funding. The fact that the National Health Strategy is not costed creates a risk. Specifically, at the time of the evaluation field mission, stakeholders were waiting to hear about the future of GFATM in Tajikistan, which currently covers more than 70% of HIV-related expenses in the country. Their information ranged from GFATM phasing out of Tajikistan to the Fund introducing a new funding model with the Government of RT as principal recipient. For UNFPA, therefore, the financial sustainability of the UNDP/GFATM-supported HIV prevention project - its largest project in financial terms - is most uncertain.

Finding 61: Natural disasters and other emergency settings present a critical threat to UNFPA-supported results. The CO has taken measures to safeguard the durability of CP outputs and outcomes.

Tajikistan is a high-risk country for emergencies. Weather-related natural disasters - e.g., harsh winters, floods, droughts, and earthquakes - have threatened and will continue to be a risk to the well-being of UNFPA's targeted beneficiaries and the sustainability of its work and accomplishments. Moreover, uneasy situations in and with Tajikistan's various neighbouring countries require constant alertness, preparedness and responsiveness. Particularly acute, for some interviewees, is the withdrawal of coalition forces from Afghanistan planned for 2015 and its potential consequences (e.g., population influx), especially for the Tajik-Afghan border zone. As already revealed in the chapter on relevance, emergency preparedness is a declared priority of the CO. UNFPA is member of the multi-stakeholder Rapid Emergency Assessment & Coordination Team (REACT), and in particular its health cluster, where, inter alia, it collaborates with WHO to ensure integration of the Minimum Initial Service Package (MISP) toolkit to save lives and prevent illness, especially among women and girls, in the case of emergencies.

4.5. STRATEGIC POSITIONING

This chapter assesses the strategic positioning of UNFPA in Tajikistan along the evaluation criteria "coordination within the UNCT", defined as the extent to which UNFPA has been an active member of and contributor to existing coordination mechanisms of the UNCT, and "added value", defined as the extent to which the UNFPA CP adds benefits to what would have resulted from other development actors' interventions only.

4.5.1 Coordination within the UN Country Team

EQ8: To what extent has UNFPA contributed to the functioning and consolidation of UN country team coordination mechanisms?

[131] The June 2013 UNDP/UNFPA Executive Board delegation to Tajikistan confirmed that the demand for financial support is strong in many areas and that the UN is expected to continue to provide its share of funding.

UNFPA is one of 23 UN funds, programmes and specialized agencies that constitute the UNCT, the largest presence in the CIS and Eastern Europe Region.[132] As such, the CP is expected to contribute to the achievement of the UN Development Assistance Framework (UNDAF) 2010-2015, the strategic programme framework, which describes the UN joint response to the country priorities in the NDS.

Finding 62: The UNDAF and UNFPA country programme are compatible. Evidence reveals that the CO takes coordination seriously. Within the large UNCT, UNFPA is perceived to have provided particular leadership in the areas of youth and communication.

Interviews and documentary analysis suggest that the UNDAF and the UNFPA CP are compatible. On the one hand, the UNDAF reflects the interests, priorities and mandates of UNFPA in Tajikistan. On the other, the CP outcomes and outputs derive from the UNDAF, particularly UNDAF Outcome 1 for PD and GE and UNDAF Outcome 2 for RH and GE. No interviewee was aware of any UNFPA interventions being implemented outside the scope of the UNDAF.

The UNCT is currently in the process of elaborating a new UNDAF. In this connection, a so-called Core Group has been established with UNFPA as member, a "road map" has been elaborated, and an evaluation of the current UNDAF is ongoing. A renewed country analysis is planned to update the last Common Country Assessment (CCA) that dates from 2004. Information gathered from interviews with different UN agencies suggests that the UNDAF preparation phase - at the time of the evaluation field mission - was still limited to a select circle of management and more senior-level programme staff, and that technical staff had not yet been actively involved. Asked about room for improving the reflection of UNFPA's mandate in the new UNDAF (keeping the SP 2014-2017 in mind), one UNCT interviewee suggested including a stand-alone outcome on gender; another took the view that demography could be more strategically positioned; yet another emphasized the need to reflect the growing importance and needs of young people.

At the time of the field mission, the CO was chairing three of the five TWGs - i.e., the Gender Theme Group (GTG), the Youth Thematic Group[133] and the UN Communication Group (UNCG); in the past it chaired the Operations Management Group twice. It is member of the Joint HIV/AIDS Group and of the Health Theme Group. Evidence shows that UNFPA Tajikistan takes coordination seriously. Despite its relatively small in-country presence, interviewees considered it a very active and respected UNCT member. Numerous UNCT interviewees gave the CO particular credit for its leadership role in the cross-cutting areas of youth and communications. While no formal working group exists, some also mentioned UNFPA's contribution to UN system coherence in the area of data and statistics for development.

Besides participating in coordination mechanisms, in an overall context of a limited number of joint programmes, UNFPA has also been and continues to be involved in joint programming with other UNCT members in all programmatic areas. Examples are support for the Ombudsman, empowering communities in the Rasht valley, strengthening health system capacity in reproductive and maternal health, and the UN joint advocacy project on HIV (UNJAP). To the extent that the evaluation team is aware, joint programmes have not been evaluated.

4.5.2 UNFPA Added Value

EQ9: What is the main added value of UNFPA's interventions in Tajikistan as perceived by national counterparts and other development actors?

Finding 63: UNFPA adds value because of generic corporate features such as its mandate to procure contraception and thanks to country-specific comparative strengths. Stakeholders particularly appreciate the high personal commitment of UNFPA CO staff members.

[132] Report of the field visit of the Executive Board of UNDP/UNFPA/UNOPS to Tajikistan, 24 to 30 June 2013. Tajikistan is not a Delivering as One United Nations country.
[133] UNFPA is a founding member of the Youth Thematic Group, established in 2013.

Satisfaction with UNFPA as a partner is overwhelmingly high among technical and senior-level national and international partners. The high personal commitment of UNFPA CO staff members was emphasized, described for instance as “responsive”, “uncomplicated”, “flexible”, “friendly” and “non-judgemental”.

Compared with other development actors working in similar areas, an analysis of the UNFPA CP and stakeholder interviews reveals a number of comparative strengths. At the level of the organization - i.e., resulting from generic corporate features of UNFPA, they are:

- Leading procurement agency for contraceptives and related commodities (or as one interviewee said “the go-to agency”);
- Lead agency for promoting maternal health standards and protocols;
- Lead agency for Population and Housing Census; and
- Lead agency within the UN system for empowering SWs and MSM to protect themselves from HIV.

More country-specific comparative strengths are:

- High-level of technical - i.e., medical, expertise in MH and FP;
- Ability to engage with and mobilize both NGOs and public sector actors, particularly the MoH;
- Privileged access to the Committee on Religious Affairs; and
- Respect for national leadership, without imposing an institutional agenda.

PART 5: MONITORING AND EVALUATION

This part assesses the design and implementation of the CO monitoring and evaluation system.

EQ5: To what extent have UNFPA country office monitoring and evaluation mechanisms helped steer the country programme?

According to the CPD, approved by the UNDP/UNFPA Executive Board in 2009, UNFPA and the Government of RT should develop a M&E plan, aligned with the UNFPA SP, the UNDAF, the NDS and national plans to achieve the MDGs. The government and partner organizations should conduct joint monitoring, reviews and evaluations, using participatory methods that involve local partners. UNFPA should track programme indicators and contribute to monitoring and evaluating UNDAF outcomes. According to the CPAP, subsequently signed between UNFPA and the Government of RT, regular monitoring of programme activities should furnish information on operations to improve programme implementation. A CPAP Planning and Tracking Tool (CPAP PTT) and CPAP Monitoring and Evaluation Calendar (CPAP MEC) should serve as tools for monitoring and tracking progress in programme delivery.

Finding 64: The CO has made very good efforts to monitor its performance in a results-oriented manner. The design of the CPAP PTT is thorough, but its use not yet fully dependable.

Overall, the evaluation team can confirm the existence of a CPAP PTT. It can also confirm that the UNFPA CO has conducted regular monitoring missions (annex 8), together with concerned national and international partners, and that it has organized annual reviews of CP implementation with partner participation. There is a CPAP MEC for 2010-2015. However, it has never been reviewed or updated and is not being used as a management tool.

In 2011, the UNFPA CO introduced a CPAP Planning and Tracking Tool (CPAP PTT), in the form of Excel sheets, and designated roles and responsibilities. The tool consists of three elements:

- An overview of expected CP outcomes and related CP outputs for each programmatic area (RH, GE and PD), including outcome and output-level indicators, means of verification, responsible party, baselines and targets as well as risks and assumptions. The overview was modified in 2012 to reflect the aligned CP results framework and to include the revised UNFPA SP outputs and outcomes to which the CO intended to contribute to at the corporate level;
- Semi-annual and annual progress reports for each project against (revised) indicators and - since 2012 - "milestones" for the year in question, including - since 2013 - information on indicative resources (RR and OR); and
- In 2013 and 2014[134], an overview of "cumulative results" for RH, GE and PD respectively, including means of verification and indicative resources.

The CPAP PTT is at the heart of the CO's planning, monitoring and reporting. It is a straightforward and user-friendly tool, embedded in the CPAP Results and Resources Framework. In 2012, some important changes were made: the SP alignment exercise was reflected; "annual milestones" were included; and a "cumulative results" sheet was added. NPOs/NPAs are responsible for filling in the templates. The NPO for PD is simultaneously the CO M&E focal point. In 2013, the CPAP PTT was reportedly[135] among the finalists of a global UNFPA M&E competition.

It is beyond the scope of this CPE to comprehensively assess the CO monitoring system, but a case study by the evaluation team of implementation of the CPAP PTT and how it relates to planning and reporting in the case of one of the three CP programmatic areas[136] suggests that the way the tool is

[134] June 2014 semi-annual report.
[135] Source: UNFPA CO.
[136] GE programmatic area. See annex 10 for details of the review.

being used is not yet fully dependable in terms of providing adequate evidence-based performance information for steering the country programme.

In the present case study, most importantly, progress towards the CPAP outcome has not been monitored since the 2012-alignment exercise. Also, while annual milestones are very useful to have in theory, the reader is unable within reasonable time to trace the origins of individual milestones to "activities" listed in the AWPs and to make the connection between the planning document and the monitoring tool at this particular level; nor is it evident how CPAP PTT reporting on the milestones (as well as on outputs and outcomes) feeds into SPRs[137]. Furthermore, in the present case study, information provided in the "cumulative results" sheets does not show progress towards targets set for the entire programme cycle. It is not cumulative, showing the incremental achievement of outputs and outcomes. All it does, in actual fact, is to pull together in one place results reported for each semester and each year. In addition, there are inexplicable discrepancies between semi-annual and annual progress reports and data contained in the cumulative results sheets.

By means of the case study, the evaluation team would like to point out some further weaknesses in using the CPAP PTT in the bullet points below:

- Missing baselines, including at the outcome level;
- No sources of information for existing baselines;
- Annual milestone indicators formulated as targets;
- Annual milestone indicators that are not monitored;
- Monitoring data of limited utility because of an over-reliance on quantitative data; and
- No monitoring of risks and assumptions.

Finding 65: UNFPA Tajikistan has produced reasonable evaluative evidence for learning and planning purposes, especially in MH and FP.

The UNFPA evaluation policy does not envisage systematic and regular decentralized evaluations at the country level. According to the 2009 UNFPA Evaluation Policy (revised in 2013), UNFPA COs should merely ensure that evaluations are undertaken with their IPs and within the programmatic framework. Since 2010, the Tajikistan CO has conducted a number of reviews and evaluations of its work, especially in MH and FP (see bullets below), which the present evaluation has used as sources of information. UNFPA interventions in the areas of HIV prevention and ASRH have not undergone any external assessments since 2010.

- 2010: External assessment of CLMIS;
- 2011: Joint assessment of the quality of care to mother and child at hospital level;
- 2011: Joint assessment of confidential enquiry of maternal mortality and near miss case analysis within the context of BTN;
- 2011: Evaluation of the effectiveness of the GE programmatic area;
- 2011: Independent evaluation of the 2010 Population and Housing Census;
- 2012: Technical review of UNFPA's training materials;
- 2013: Joint assessment of quality of antenatal care at the primary health care level;
- 2014: External assessment of CLMIS.

[137] SPRs report against "strategic activities". Similar to the annual milestones, they do not clearly mirror activities listed in the AWPs.

PART 6: CONCLUSIONS

In line with the UNFPA CPE Handbook, the present chapter presents the evaluation team's strategic and programmatic conclusions based on the assessment above. Strategic conclusions refer to the CP as a whole and are structured along relevance, efficiency, sustainability, strategic positioning and M&E; programmatic conclusions address the different projects under UNFPA's programmatic areas and deal largely with the evaluation criterion effectiveness.

Starting with a synthesis of evaluation findings, conclusions go on to reflect on the one hand the evaluation team's professional opinion of UNFPA's performance during the period under evaluation and, on the other hand, are forward looking, leading up to recommendations in part 7 of this report.

6.1 Strategic Conclusions

6.1.1 Relevance

The evaluation team concludes that activities implemented under the UNFPA Tajikistan CP 2010-2015 are - and continue to be - very relevant, both at the national and international levels.

Findings for EQ1[138] reveal that the current CP addresses important SRH-related rights and needs of women, young people and HIV key populations in Tajikistan; it responds to civil society demands for more and better quality social and demographic data and evidence for policy-making and decision-taking. At the same time, the CP, co-implemented with concerned national authorities, serves to establish and uphold government priorities and commitments towards these groups.

UNFPA has rightly focused on the health and well-being of women and young people in Tajikistan; it is one of very few organizations to speak up and provide for harassed and hushed up sex workers (SWs) and men who have sex with men (MSM). The evaluation team sees no need to change this focus; rather the need for continuity. It does, however, see scope for the next CP, besides implementing interventions of national importance, to give more consequent emphasis to rural areas of Tajikistan where over two thirds of the population live, where inequities prevail and where most labour migration occurs.

UNFPA, over the current programme cycle, has successfully influenced and aligned itself with national policies and legislation - e.g., the revised Law on Reproductive Health and Reproductive Rights, the Law on the Prevention of Domestic Violence, the updated Law on HIV and AIDS and the National Youth Policy. In line with UNFPA's corporate business plan and Tajikistan's classification as an "orange" country - i.e., one that has high needs and a lower to middle ability to finance - the CO should increase its engagement in advocacy and policy dialogue with national authorities in an approach that ideally would culminate in results-oriented and budgeted policies and plans as well as increased resources from the state budget. At the same time, UNFPA should continue to build national capacities; it should identify ways to reduce direct service delivery, such as the procurement of commodities, thus also reducing dependence and contributing to sustainability.

At the international level, findings for EQ2[139] show that the UNFPA CP is firmly anchored in international development and human rights agendas and ongoing processes, notably with regard to the MDGs/SDGs, the ICPD, CEDAW and UPR. The CP results framework is aligned with the objectives of the UNFPA Strategic Plan 2014-2017. In terms of corporate cross-cutting issues - i.e., gender, youth, South-South cooperation and emergency preparedness - the CO has paid high attention to mainstreaming women's and young peoples' concerns. It declared emergency preparedness a priority and took important steps to ensure coordination and increase national preparedness. In 2010, it helped save lives during massive rains and mud slides in Kulyab.

[138] EQ1: To what extent is the UNFPA country programme consistent with beneficiary needs and government priorities?

[139] EQ2: To what extent is the CP consistent with the MDGs, the ICPD agenda and UNFPA strategic plans?

It is commendable how the CO has actively been involved in shaping discussions around the future SDGs and ICPD agenda, from a Tajik perspective. UNFPA's 4th CP will need to take these new developments into account. The CO should also design the next phase based on an analysis of CEDAW commitments and accepted UPR recommendations (not explicitly referenced in the current CPD and CPAP). At the corporate level, to align with the four strategic outcome areas and the greater importance given in the SP 2014-2017 to young people, the new CP should include a new and budgeted programmatic area "adolescents and youth" (rather than merely a project under the RH programmatic area as is the case today). This makes all the more sense given the considerable number of young people in Tajikistan and their needs. Furthermore, based on evaluation findings, the evaluation team sees scope for a more strategic and results-oriented approach to mainstreaming corporate cross-cutting issues in UNFPA's CP to achieve results, including at the level of advocacy and policy dialogue,. Given the recent identification by UNFPA of Tajikistan one of the programme countries facing the highest risks of humanitarian crises[140], investments in the CO to mainstream humanitarian action into programming and further preparedness can be expected to grow in view of efficiently and effectively supporting the recently approved National Action Plan for RH in Emergencies.

- **Strategic Recommendations A3, A4, A5, A6, A7**

6.1.2 Efficiency

In terms of resource mobilization and allocation, findings for EQ6[141] reveal that UNFPA HQ has made RR available to the extent planned, and that the CO has implemented the initial plan to emphasize RH followed by PD and GE. At the same time, GE and HIV prevention received more RR than originally envisaged; MH and FP saw significant funding reductions. Only 57% of planned OR have been mobilized, and this mainly thanks to HIV prevention among key populations. Nevertheless, while OR are below target, total annual resources have continually grown since 2011, and the outlook is positive due to the arrival on the scene of new donors and parallel funding.

The evaluation team understands the reasons for allocating more RR to GE and HIV prevention than planned given the circumstances and opportunities, including the ability to mobilize considerably more than matching funds from UNDP/GFATM for HIV prevention. It is unfortunate that MH and FP thus received less, but this does not seem to have been to the detriment of any of the two projects. As regards OR - earmarked contributions to the UNFPA budget - the CO's performance has been unsatisfactory and heavily skewed towards the HIV prevention project. Arguably, the CO has also reported considerable parallel funding ($1,796,116), just over half of which for PD, which is another way of supporting UNFPA's causes, although it is not evident to what extent UNFPA was the trigger and can take credit. In fact, this financing modality might become more and more important in future - as an alternative to OR - given the complexity of development interventions, donor preference to preserve one's own identity and demonstrate results, and the quest for administrative efficiency. The question thus arises how to define, plan and account for parallel funding in UNFPA CPs as part of results-oriented budgeting.

In terms of programme expenditures (RR and OR), findings for EQ6 are positive and the evaluation team commends the CO. They show justifiable AWP revisions, across the board timely delivery and a very high financial project implementation rate (only in exceptional cases below 97%). In line with the corporate emphasis on NEX, evaluation findings also reveal a preferred and generally unproblematic use of NEX. Furthermore, interviewed beneficiaries felt that they had received value for money. The percentage of total programme resources expended on RH, including HIV, amounted to 66%. This compares well with the commitment for SRH to receive up to 70% of total UNFPA

[140] In connection with UNFPA SP 2014-2017 funding arrangements.

[141] EQ6: To what extent has the UNFPA country office made good use of its financial and human resources to implement the country programme?

programme resources by 2017.[142]

In terms of administrative costs, the evaluation team suggests that actions must be taken to assess potential cost savings: According to Atlas project monitoring data, administrative costs (project support costs plus PCA and BSB expenditures) have constantly grown and over the 2010-2013 period have amounted to a third of all expenditures.[143]

In terms of human resources, findings for EQ6 assert that current institutional arrangements for managing and supervising the CO are challenging because of three management layers and the involvement of UNDP, geographical distance, and competing priorities. CO human and technical, resources for implementing the CP are considered appropriate with room for improvement.

The evaluation team is able to relate to the concerns related to the shared leadership of the CO, although any weaknesses in the organizational set-up momentarily and fortunately do not seem to have had any significant implications on working relationships or performance thanks also to the persons involved. However, in terms of risk management, and possibly also for the benefit of other COs in similar situations, UNFPA would be well advised to review the duties and responsibilities of and relationships between ARs, CDs and UNFPA Representatives where jointly responsible for a particular UNFPA CO and to consider updating the MoU with UNDP, and not to bank on continued professionalism, intuition and good will of concerned individuals. As for the use of CO human resources, the evaluation team proposes that structure should follow substance. In other words, it supports the suggestion to review the current organigram and staffing in connection with the 4th CP and UNFPA's revised business model. This said, given its suggested greater profile, the CO should be prepared to increase capacities to manage the new adolescents and youth programmatic area.

- **Strategic Recommendations B1, B3, B4, B5, B6**

6.1.3 Sustainability

The evaluation team has determined that sustainability is a weak aspect of the CO's planning, monitoring and reporting. Based on data collection and analysis in connection with EQ7[144], it has identified four factors and conditions with great potential to affect the sustainability of UNFPA-supported results - i.e., political commitment and institutional capacity, financial resources, UNFPA corporate priorities and the human security situation; the latter two were discussed under the relevance criterion above.

The CO has built important partnerships with a row of executive and legislative state branches within and outside the health sector, as direct beneficiaries and/or IPs. This has helped - to differing extents - to build ownership and thus to make continuation of benefits more likely. Nevertheless, the evaluation team suggests that partnerships be reviewed in the context of planning the next CP. For instance, based on available evidence it is questionable whether it makes sense to continue working with the Ombudsman Office despite the theoretical importance of doing so. On the other hand, it could be wise to include the MoE as new Implementing Partner for the suggested adolescents and youth programmatic area, the MoHSP for the GE and women's empowerment programmatic area, the MEDT in the area of population dynamics and to work closely with the Republican AIDS Centre in the area of HIV prevention (as part of the SRH programmatic area). Given UNFPA's role as trusted partner and the potential that stakeholders perceive, the evaluation team would also recommend a continued collaboration with the Religious Committee and faith-based organizations. In any event, it seems crucial that the CO invest time in building a functioning relationship with newly-elected parliamentarians post elections scheduled for 2015.

[142] UNFPA Integrated Results Framework, Organizational Effectiveness and Efficiency, Output 2, Indicator 2.12.
[143] According to SP 2014-2017 Organizational Effectiveness and Efficiency Output 2, Indicator 2.3, the percentage of total income used for recurring management costs should not exceed 11.2%.
[144] EQ7: To what extent has the UNFPA country office identified and addressed factors and conditions affecting the sustainability of UNFPA-supported results?

As regards financial resources, the Government of RT cannot be expected to step in on a large scale. For instance, it appears that the country will still be dependent on external resources for the production of reliable data, both regular administrative data and surveys. Resource mobilization (RR, OR, parallel funding) therefore remains all the more important for maintaining and leveraging UNFPA-supported results, and, generally speaking, the outlook is positive given the substantial increase in ODA over the recent past years. However, again, continuing and sustaining UNFPA's work with SWs and MSM seems particularly at risk, given the uncertain future of GFATM in Tajikistan and donor-dependency of involved NGOs. The CO would therefore be well advised to start planning for a next phase and exploring possible financial pipelines, including UNFPA RR.

- **Strategic Recommendation B2**

6.1.4 Strategic Positioning

The evaluation team concludes that UNFPA in Tajikistan is well positioned within the development community and national partners, in view of its ability to respond to national needs while adding value to country development results. Its contribution to UN system coherence is very valuable.

Findings for EQ4[145] (development partnerships) reveal that UNFPA has made good on its intentions to collaborate closely with other development actors, and that UNFPA's partners are most often sister UN agencies. UNFPA CO staff clearly agreed that partnerships accelerate progress towards the Fund's objectives in Tajikistan: Benefits mentioned were parallel funding, access to new funding sources, programmatic synergies and opportunities to expand pilots. Findings for EQ8[146] (UNCT coordination) show that the current UNDAF and the UNFPA CP are compatible, and that the CO has taken seriously pursued coordination in all areas of work. Findings for EQ9[147] (added value) demonstrate that UNFPA has added value because of generic corporate features such as its mandate to procure contraception, but also thanks to country-specific comparative strengths. Interviewed stakeholders particularly appreciated the high personal commitment of UNFPA CO staff members.

This situation is an ideal starting point for developing a next CP that is embedded in and contributes to the new UNDAF 2016-2020 and that continues to build on partnerships and comparative advantages. In this connection, the evaluation team would urge the CO and the Government of RT to start the strategic planning process of the 4th CP as soon as possible and in a participatory manner - inter alia based on the results of this CPE - and to invest sufficient time in the ongoing UNDAF preparation process in order to ensure that UNFPA's interests and strengths are optimally reflected and logically linked.

- **Strategic Recommendations A1, A2**

6.1.5 Monitoring & Evaluation

Monitoring and evaluation are related and complementary functions, intended to provide pertinent information for decision takers. The evaluation team concludes that the UNFPA Tajikistan CO has taken performance monitoring very seriously. Findings for EQ5[148] reveal that CO staff members spend a significant amount of working time with "their" projects; a relatively simple and practical monitoring system is in place, which staff members dutifully complete. However, a case study has alerted the evaluation team to certain weaknesses in using the CPAP PTT that require management action in view of effectively and uniformly steering the CP.

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[145] EQ4: To what extent has the UNFPA country office successfully used partnerships with other development actors to achieve its objectives?

[146] EQ8: To what extent has UNFPA contributed to the functioning and consolidation of UN country team coordination mechanisms?

[147] EQ9: What is the main added value of UNFPA's interventions in Tajikistan as perceived by national counterparts and other development actors?

[148] EQ5: To what extent have UNFPA country office monitoring and evaluation mechanisms helped steer the country programme?

Furthermore, evaluation findings demonstrate that the CO has produced reasonable evaluative evidence on its performance for learning and planning purposes, especially in MH and FP. On the other hand, UNFPA interventions in the areas of HIV prevention and ASRH have not undergone any external assessments since 2010.

- **Strategic Recommendations C1, C2**

6.2 Programmatic Conclusions

Overall, the evaluation team concludes that UNFPA has been effective. Over the past four and a half years, it has built important national capacities within and outside the health sector that are being put to good use for the benefit of the Tajik population, and particularly women. Results in the area of family planning and maternal health are most impressive given their scale and their contribution to strengthening the Tajik health system.

6.2.1 Family Planning

The evaluation team is of the opinion that it is largely thanks to UNFPA that the availability and quality of family planning services in Tajikistan have increased over the past years.

Findings for EQ3b[149] reveal that UNFPA remains the sole agency supplying contraceptives to the Tajik public health system; since the beginning of the CP in 2010, the number of modern contraceptives has increased from four to eight types, including contraceptive implants, thus giving each individual and couple more possibilities to choose a desired family planning method. Thanks to the upgraded Contraceptives Logistics Management Information System (CLMIS), around two-thirds of service delivery points are now in the position to ensure availability of at least three modern methods at any given time. In an attempt to reduce the country's dependency on UNFPA for contraceptive commodity supplies, first steps have been taken to introduce a Total Market Approach (TMA). In parallel, the Fund has trained RH academicians, teaching staff and service providers, including midwives, to apply modern family planning methods. Today, Tajikistan is also better prepared to respond to the RH needs of its population in emergencies.

Nevertheless, international and national statistics continue to expose low contraceptive prevalence and an unmet demand for contraception, which are also a cause of high rates of maternal and perinatal mortality. The evaluation team thus concludes that more efforts are required to increase demand for and supply of modern contraceptives and improve the quality of gender-sensitive and youth-friendly FP services. In this sense, recent steps to engage other development actors are very welcome - e.g., cooperation with USAID to undertake more research on population perspectives of modern methods of contraceptives. In terms of sharing the burden and creating synergies, the evaluation team also appreciates UNFPA's initiative to advocate for and facilitate state procurement of RH commodities through a Total Market Approach.

- **Programmatic Recommendations SRH1, SRH2, SRH3, SRH4, SRH5, SRH6, SRH7**

6.2.2 Maternal Health

Very much in concert with other development actors, and in the near absence of domestic resources, the evaluation team is of the view that UNFPA has helped to considerably increase the availability and quality of maternal health services in Tajikistan, including EmOC.

Findings for EQ3a[150] disclose that accomplishments are numerous. They include the introduction of effective perinatal care (EPC) standards in the workplace and curricula, the organizational reform of the maternity referral system, the establishment of equipped EmOC institutions, the upgrading of

[149] EQ3b: To what extent has UNFPA strengthened national capacities to supply essential reproductive health commodities, including those used in natural disasters and other emergency situations, resulting in increased availability and utilization of quality family planning services?

[150] EQ3a: To what extent has UNFPA strengthened national capacities, contributing to increased availability and utilization of quality maternal health services and emergency obstetric care?

midwifery services, the roll out of WHO's Beyond the Numbers (BTN) approach, and the elaboration of a National Plan of Action on Cervical Cancer Prevention (yet to be approved). Furthermore, it is noteworthy that UNFPA has started to provide rapid HIV tests for pregnant women in the context of antenatal care, and that it is the only organization to do so; it has made available ambulances, essential medical equipment and medicines for EPC and EmOC. The Fund has also contributed to bringing the quality of national live birth statistics and analysis in line with international standards, but data are not yet fully reliable.

Although the present evaluation did not assess impact, the evaluation team considers it safe to conclude that UNFPA has thus contributed to reducing the MMR in Tajikistan, albeit one that remains high irrespective of which data is consulted. More efforts are required.

Based on the evidence and findings presented above, the evaluation team concludes that UNFPA should pursue ongoing processes to increase national capacity, including in rural areas, to deliver comprehensive maternal health services while using the new CP to bring around a greater focus on and better involvement of rural maternity houses. More specifically, UNFPA should advocate for an increase in the national budget and more ODA to cover costs of investments in buildings and facilities, communication and transportation services, medical equipment, technologies and drugs. It should facilitate a better understanding of the necessity to and ways to integrate family medicine in antenatal care; scale up efforts to prevent cervical cancer; ensure availability of drugs; and help strengthen the statistical capacities of the public health sector.

- **Programmatic Recommendations SRH1, SRH7, SRH8, SRH9, SRH10, SRH11, SRH12, SRH13, SRH14**

6.2.3 HIV Prevention

UNFPA work in the area of HIV prevention among young people and - since 2013 - among female sex workers (SWs) and men who have sex with men (MSM) can be considered effective.

Findings for EQ3c[151] affirm that UNFPA has helped to increase the number of young men and women who are able to identify ways to prevent and who reject misconceptions about HIV transmission. In addition, despite difficult circumstances, UNFPA-supported NGOs have played an important role in preventing HIV among thousands of SWs and MSM. However, overall, the proportion of young people with correct knowledge of HIV remains low in Tajikistan; as seen above, one third of registered HIV cases are among 15-24 year old people. Outreach and HIV services are changing the behaviours of SWs and MSM, but not respect for their human rights. SWs and MSM continue to be confronted with stigma and discrimination, making them difficult to reach.

Thus, the evaluation team concludes that UNFPA should continue to support efforts to prevent HIV among such vulnerable groups during the next programme cycle, including through mainstreaming in other areas of its work. From a human rights and public health point of view, it should expand its interventions to include efforts to reduce stigma and discrimination against SWs and MSM. Since the situation and needs of young people differ considerably from those of SWs and MSM, and since different actors are involved, the team sees merit in designing two separate projects as part of the 4th CP.

- **Programmatic Recommendations SRH15, SRH16, SRH17, SRH18**

6.2.4 Adolescent Sexual and Reproductive Health

The evaluation team considers the ASRH project to have been effective. It has contributed to putting ASRH on the national development agenda, especially in the health and education sectors. Findings

[151] EQ3c: To what extent has UNFPA strengthened national capacities, contributing to better knowledge of HIV among young people and increased provision of quality HIV/STI prevention services for other vulnerable groups?

for EQ3d[152] show that, as planned, and by way of mobilizing other UN agencies, UNFPA has successfully promoted an increased priority on young people in national development policies. Together with UNICEF, the Fund has sensitized and equipped the public health system to address young people's SRH (including HIV) needs regardless of their marital status; Tajik secondary schools are about to introduce healthy lifestyle into their curriculum.

However, as seen above, young people's awareness of SRH remains low and young women are far less likely to use condoms and other methods of contraception than older women. The adolescent fertility rate is worryingly high; the number of registered abortions has increased. Looking forward, the evaluation team considers UNFPA's efforts, together with UNICEF and the MoE, to promote and facilitate the introduction of sexuality education in Tajik secondary schools to be an invaluable "push factor" with great potential for improving the situation. As a complementary measure, and to meet the needs of young people outside the formal education system, and especially young women, peer education remains a pertinent complementary measure.

The suggested future adolescents and youth programmatic area should be designed not only in consultation with institutional partners such as Y-PEER, UNICEF, the Youth Committee, the MoHSP and the MoE, but also with the active involvement of young people themselves as agents of change. It should build on assets and results achieved under the current HIV prevention and ASRH projects. Its efforts should go beyond the health care system (covered under outcome 1) and into other relevant sectors whose contributions can improve SRH and reproductive rights of young people.

- **Programmatic Recommendations A&Y1, A&Y2**

6.2.5 Population and Development

UNFPA work in the area of population and development has been effective. Findings for EQ3e[153] ascertain that UNFPA can claim credit for a good quality 2010 Population and Housing Census. Partnering with the Statistical Agency, it has helped modernize population data collection, especially at central and regional levels, and lay the foundation for better data analysis and dissemination. Moreover, UNFPA has sponsored surveys such as the DHS and promoted population dynamics as part of national policy dialogue. A key accomplishment is that, for the first time, a population dynamics chapter was included in the Living Standards Improvement Strategy 2013-2015.

While a basis has been laid, the evaluation has found weaknesses within the Statistical Agency at district level as compared to central and regional levels. Evidence also points to unsatisfied needs of national specialists for more and better data and in-depth analysis, in particular on SRH-related topics - e.g., as regards VAW, HIV key populations, early marriages, unmet contraception coverage and live births. Such data will also constitute important baselines and inputs for developing and monitoring the contribution of UNFPA to national objectives during the 4th CP cycle.

- **Programmatic Recommendations PD1, PD2, PD3, PD4, PD5, PD6**

6.2.6 Gender Equality

Overall, the GE programme has made a difference, although not quite reaching its potential in terms of strengthening the health sector's response to VAW.

[152] EQ3d: To what extent has UNFPA strengthened national capacities, contributing to increased availability and utilization of youth-friendly sexual and reproductive health services and age-appropriate sexuality education?

[153] EQ3e: To what extent has UNFPA strengthened government capacities to collect and analyse population data to address social gaps and disparities, contributing to population information being increasingly included in government laws, policies, strategies and development programmes at national and local levels?

Findings for EQ3f[154] reveal that given the dearth of shelters in Tajikistan, UNFPA's initiative to pioneer victim support rooms (VSRs) in state maternity hospitals for temporary stay of women victims of violence is very welcome. However, the currently eight pilot victim support rooms are under-utilized, as are the two state facilities outside the health sector that UNFPA is supporting. This can be ascribed to deeply-engrained cultural norms and insufficient knowledge about the VSRs among women and actors working in the area of women's rights and GBV. Moreover, interviewed health personnel felt insufficiently qualified to approach and refer victims of violence.

VAW is a human rights violation in itself; it also severely affects women's and girls' SRH and reproductive rights. Although only partially fulfilling their purpose, the VSRs in the health sector call for further investments in time and money as part of implementing the new law and national programme on domestic violence and fulfilling CEDAW commitments. For the remaining part of the 3rd CP, UNFPA and the MoHSP should focus on ensuring application of the VSR regulation, informing other actors and potential clients about their existence and the types of services offered (i.e., increasing their visibility), embedding the VSRs in GBV reference systems, and ensuring reliable data management. Based on additional experience, and possibly an in-depth evaluation of the initiative, the MoHSP should then consider increasing the number of VSRs. VSRs cannot function in isolation. Priority should therefore be given to locations where complementary prevention and protection services exist or where there is potential for creating them, thus ensuring an effective multi-sectoral response to each individual case, including for the most vulnerable women in rural and mountainous areas. In addition to the VSRs, UNFPA and the MoHSP should consider complementary ways to improve the health sector's response to VAW - e.g., by institutionalizing pre- and in-service sensitization and screening trainings[155], something that so far, according to interviewees, does not exist in Tajikistan.

Furthermore, findings for EQ3g[156] show that UNFPA has been active on various fronts outside the immediate remit of the health sector to influence gender relations. At the policy level, working with others, it has improved official reporting under CEDAW and UPR; it was involved in the formulation of Tajikistan's first domestic violence law, the promotion of an increased minimum legal age of marriage and the revision of the law on reproductive health. At the level of state institutions, UNFPA facilitated recommendations for improving the gender sensitivity of the Tajik justice system; it collaborated with others to encourage the Ombudsman Office to champion women's rights and to involve religious leaders in reducing gender stereotypes and harmful practices. It helped secure a commitment of the current parliament to screen laws from a gender perspective. UNFPA also collaborated with NGOs and sports federations to transform gender relations. A key accomplishment was the creation of the National Taekwondo Federation movement for gender equality and the empowerment of women and girls.

The advancement of GE and women´s empowerment is a goal in itself besides being central to achieving success on SRH outcomes. UNFPA, together with partners, has achieved some important accomplishments in gender equality outside the health sector. It is commended for having pursued a balanced approach to engaging governmental and non-governmental stakeholders to promote positive norm change and to address barriers that impede progress towards gender equality and women's empowerment. Nevertheless, there are "loose ends" - e.g., work in the area of early marriage - and deplorable statistics - e.g., the percentage of women that accept wife-beating - that

[154] EQ3f: To what extent has UNFPA strengthened national health system capacities, contributing to increased provision and utilization of quality support services for women victims of violence?

[155] Reference is made to the UNFPA-WAVE Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia Resource Package as possible modality; http://www.health-genderviolence.org/complete-resource-package-for-download/118 .

[156] To what extent has UNFPA strengthened capacities and awareness of state and civil society actors on gender inequalities, contributing to efforts to transform discriminatory social norms?

deserve and require considerable efforts and follow-up, including research and evidence gathering. That said, given limited resources and to avoid fragmentation, the evaluation team suggests that the future GE and women's empowerment programmatic area scale down its leadership and investment in non-health partners and arenas based on its comparative advantage, continued needs and an assessment of likely impact on UNFPA's overall goal - i.e., the achievement of universal access to sexual and reproductive health, the realization of reproductive rights, and the reduction in maternal mortality.

- **Programmatic Recommendations GE1, GE2, GE3, GE4**

PART 7: RECOMMENDATIONS

This last part of this report presents the evaluation team's strategic and programmatic recommendations for consideration by stakeholders. As stated in the evaluation objective, recommendations largely relate to the design of the 4th CP 2016-2020. It is important to note that they focus on the most important areas for UNFPA rather than being exhaustive. To ensure alignment, programmatic recommendations are categorized by the outcomes of the SP 2014-2017 Integrated Results Framework.

7.1 Strategic Recommendations

A. Country Programme Design

A1: UNFPA CO and MEDT to elaborate as soon as possible road map for developing the 4th UNFPA CP for Tajikistan in a consultative manner.

A2: UNFPA CO to ensure continued senior-level involvement in UNDAF preparation process with regular consultation of CO technical staff.

A3: UNFPA CO to construct the 4th CP around four programmatic areas concurring with the SP 2014-2017 strategic outcomes: SRH (including maternal health, family planning and HIV); adolescents and youth; GE and women's empowerment; and population dynamics. This implies a higher profile for UNFPA's work with and for young people than thus far.

A4: Based on recent and ongoing inter-governmental processes, UNFPA CO to use the SDGs, the UPR and CEDAW as overarching international reference frameworks for the 4th CP, besides the ICPD agenda.

A5: In line with Tajikistan's inclusion in the group of countries at particular risk of emergencies, UNFPA CO to plan for an increased preparedness for and engagement in humanitarian settings in all programmatic areas.

A6: UNFPA CO to demonstrate in the 4th CP how UNFPA aims to reduce inequities in gender relations and access to SRH services in rural areas of the country.

A7: In terms of strategic interventions, while continuing to build national capacities, UNFPA CO to increase investments in advocacy and policy dialogue, and (continue to) identify ways to reduce service delivery.

B. Programme Management and Implementation

B1: UNFPA CO to review administrative costs accruing to HQ and the CO for managing the Tajikistan CP and devise ways for future cost savings.

B2: UNFPA CO to strategize on future partners for funding and implementing the 4th CP and especially the project to prevent HIV among SWs and MSM given the political and financial risks.

B3: UNFPA CO to review current CO organigram and staffing in connection with 4th CP and revised business plan.

B4: Given its increasing significance, UNFPA HQ to provide guidance to COs on how to define, plan and account for parallel funding in support of UNFPA CPs as part of results-oriented budgeting.

B5: UNFPA HQ to clarify division of labour between ARs, CDs and UNFPA Representatives where they are jointly responsible for leading a UNFPA CO.

B6: UNFPA HQ to consider the necessity and desirability of updating the MoU between UNFPA and UNDP on UNFPA representation at country level.

C. Programme Monitoring and Steering

C1: UNFPA CO/RO to develop guidelines for using the CPAP PTT, including on its links to AWPs and SPRs, and intensify on-the-job support and quality assurance.

C2: UNFPA CO/RO to develop a work plan to ensure a regular, systematic and coordinated programme of decentralized evaluations during the 4th CP covering all programmatic areas.

7.2 Programmatic Recommendations

7.2.1 SP 2014-2017 Outcome 1: Sexual and Reproductive Health

To increase the availability and use of SRH services (including family planning, maternal health and HIV) that are gender-responsive and youth-friendly and that meet human rights standards for quality of care and equity in access, the evaluation team makes the following programmatic recommendations:

SRH1: UNFPA CO to strengthen government policy on FP and MH by supporting the MoHSP initiative to develop a comprehensive, costed, time-bound and results-oriented National Action Plan on RH.

SRH2: UNFPA CO/RO and MoHSP to gradually decrease the country's dependency on UNFPA contraceptive procurement by finalizing the TMA national action plan along with a new FP indicator on women at high risk group to be covered by contraception, while ensuring that the action plan is costed and supported by all relevant stakeholders, including the private sector.

SRH3: UNFPA CO, MoHSP and Republican Medical College to ensure the effectiveness of FP training for academicians and teaching staff of medical colleges by developing a results-oriented mentoring and monitoring plan.

SRH4: Based on stakeholder discussions and the results of the UNICEF-commissioned external evaluation, UNFPA CO to consider continued support for the YFHS programme to deliver quality SRH services for adolescents and youth.

SRH5: UNFPA CO and MoHSP to expand and ensure sustained availability of FP services and commodities at PHC level by providing refresher trainings and on-place mentoring on CLMIS and CHANNEL for regional and district-level health authorities.

SRH6: UNFPA CO and MoHSP to generate more demand for FP by combining outreach activities with other community-based health interventions.

SRH7: UNFPA to advocate for an increase in the national budget and more ODA to cover costs of investments in buildings and facilities, communication and transportation services, medical equipment, technologies and drugs.

SRH8: In order to better manage pregnancy-related complications, UNFPA and MoHSP to work with partners to strengthen services related to EmOC in line with WHO Strategy toward Ending Preventable Maternal Mortality.

SRH9: UNFPA and MoHSP to scale up the effective perinatal care programme in rural areas.

SRH10: In connection with ongoing efforts to strengthen the role of midwives who are often the only health professionals to provide obstetric and perinatal care in remote mountain areas, UNFPA CO and MoHSP to cooperate with WHO to develop midwifery workforce policies based on WHO-ICM (International Confederation of Midwives) standards.

SRH11: UNFPA CO and MoHSP to improve access to and quality of ANC services by integrating ANC with PHC (particularly family medicine); specifically by clarifying the division of labour between obstetrician gynaecologists and family doctors.

SRH12: UNFPA CO and MoHSP to scale up the national information system for maternal death surveillance and response, to build statistical capacities within the health sector and expand ILBD and ICD initiatives.

SRH13: In order to reduce cancer mortality and morbidity, UNFPA and MoHSP to introduce an internationally-recognized cervical cancer programme through screening programmes, capacity building, development of regulations and guidance and South-South cooperation.

SRH14: To increase availability of drugs and save more lives, UNFPA CO and MoHSP to seek collaboration with WHO and UNICEF to implement the WHO Priority Life-saving Medicines for Women and Children Programme.[157]

SRH15: UNFPA CO to ensure constant availability and quality of condoms for SW and MSM clients, train partner NGOs on procurement and supply management, including storage.

SRH16: To reach less-educated audiences among SW and MSM target groups, UNFPA CO to rework existing IEC materials using more images and a clear and simple language.

SRH17: UNFPA CO to support networking initiatives of people living with HIV to address discrimination and human rights, including of SWs and MSM.

SRH18: To reduce stigma and discrimination against SWs and MSM, UNFPA CO to engage with partners to devise appropriate public information and education campaigns.

7.2.2 SP 2014-2017 Outcome 2: Adolescents and Youth

Outside the health sector, to increase the priority on young people in national development policies and programmes and particularly increased availability of comprehensive sexuality education, the evaluation team makes the following programmatic recommendations:

A&Y1: Based on the "road map" (finding 29), UNFPA CO to convene partners to remove remaining legal, policy and other barriers to young people accessing quality SRH counselling and HIV services, especially young people at risk such as drug users, SWs, MSM and migrants and those living in remote areas.

A&Y2: UNFPA CO to continue to collaborate with partners to advance a successful introduction and nationwide implementation of sexuality education for secondary school students while continuing to invest in peer education to promote healthy lifestyles.

7.2.3 SP 2014-2017 Outcome 3: Gender Equality and Women's Empowerment

To advance gender equality, women's and girls' empowerment and reproductive rights, the evaluation team makes the following programmatic recommendations:

GE1: UNFPA CO to increase the focus on the linkages of GE with SRH and reproductive rights, with particular emphasis on addressing VAW and other harmful practices as well as ensuring the engagement of men and boys in the promotion of GE.

GE2: In partnership with CWFA, UNFPA CO to continue to engage in (promoting) the implementation and monitoring of actions in response to CEDAW[158] obligations and UPR accepted recommendations, with a focus on improving women's SRH and addressing VAW and other harmful practices.

GE3: In partnership with the MoHSP, UNFPA CO to continue to be involved in (promoting) the implementation and monitoring of the law and national programme on domestic violence, with emphasis on the health sector's response to VAW, including in humanitarian settings where women's vulnerability is particularly acute.

GE4: UNFPA CO to expand Stepping Stones training for Tajik NGOs to address discrimination and to promote women's empowerment, reproductive rights among local communities, including men and boys, and to change perceptions around the acceptability of VAW and other harmful practices. Establish and nurture a Stepping Stones community of practice, including a system to monitor and document follow-up and impact.

7.2.4 SP 2014-2017 Outcome 4: Population Dynamics

To strengthen national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, SRH

[157] http://www.who.int/childmedicines/prioritymedicines/en/.
[158] Keeping in mind that the next periodic report is due in October 2017.

and reproductive rights, HIV and GE, the evaluation team makes the following programmatic recommendations:

PD1: UNFPA CO and Statistical Agency to strengthen the capacities of Statistical Agency staff at district-level for producing and disseminating quality disaggregated data on population and development issues.

PD2: UNFPA CO to support the Statistical Agency to prepare and conduct the 2020 Population Census, including the use of new modern technologies and methods, and to analyse and disseminate results.

PD3: UNFPA CO and Statistical Agency to systematically strengthen line ministry (e.g., MoHSP, CWFA, and Youth Committee) capacities for producing and disseminating quality disaggregated data and analysis on SRH, adolescents and youth, and GE, in line with national priorities.

PD4: As inputs into policy-setting and monitoring, UNFPA CO to work with partners on national surveys to increase the availability of in-depth analysis of population dynamics, SRH, adolescents and youth and GE.

PD5: In collaboration with the Office of the President, UNFPA CO/ and MEDT to ensure that the Mid-term Strategic Plan for Poverty Reduction 2015-2017 and National Development Strategy address population dynamics by accounting for population trends (from census and other national surveys) and projections in setting development targets.

PD6: UNFPA CO and MEDT to build the capacities of MEDT staff for using data and evidence to monitor and evaluate national policies and programmes in the areas of population dynamics, SRH, adolescents and youth and GE.