

UNFPA Country Programme Evaluation

Bosnia and Herzegovina

Period covered by the evaluation (2013-2018)

The report is prepared under the UNFPA CLUSTER PROGRAMME
EVALUATION
of country programmes in Bosnia and Herzegovina, North Macedonia,
Serbia and Kosovo*

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

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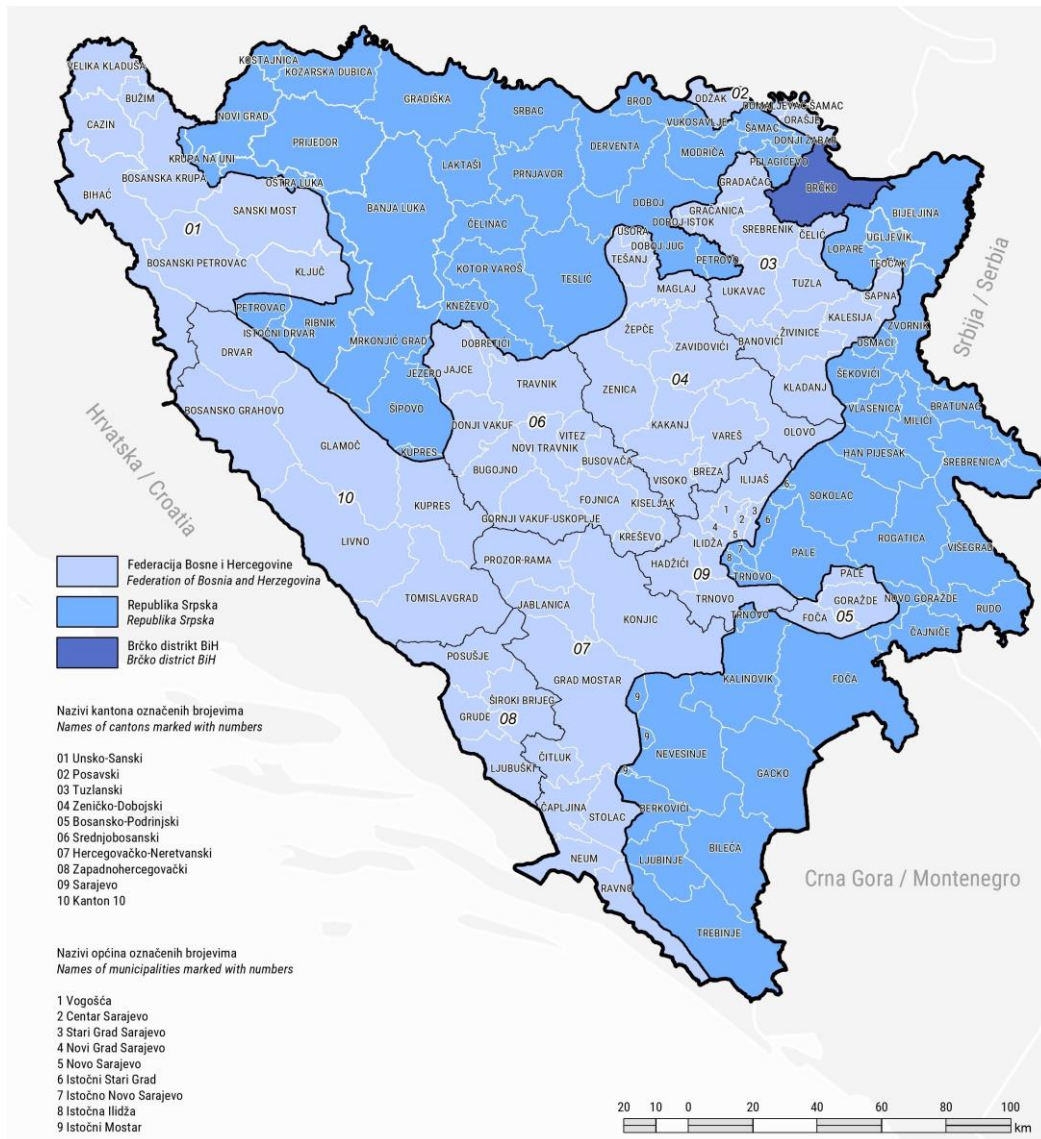
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Disclaimer

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Country Map



Administrative map of Bosnia and Herzegovina[†]

[†] Census of Population, Households and Dwellings in Bosnia and Herzegovina, 2013 - Final Results (Agency for Statistics of Bosnia and Herzegovina, 2016)

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List of abbreviations

AoR	Area of Responsibility
AWP	Annual Work Plan
BD	Brcko District of Bosnia and Herzegovina
BiH	Bosnia and Herzegovina
BtN	Beyond the Numbers
CCA	Common Country Assessment
CEDAW	Committee on the Elimination of Discrimination Against Women
CO	Country Office
CP	Country Program
CPD	Country Program Document
CPE	Country Program Evaluation
COAR	Country Office Annual Report
CSE	Comprehensive Sexuality Education
CSO	Civil society organization
CRSV	Conflict-Related Sexual Violence
DAC	Development Assistance Committee
DHS	Demographic and Health Survey
DRR	Disaster Risk Reduction
EC	European Commission
EECA	Eastern Europe and Central Asia
ERG	Evaluation Reference Group
EU	European Union
FAO	Food and Agriculture Organization of the United Nations
FBiH	Federation of Bosnia and Herzegovina
FGDs	Focus Group Discussions
FP	Family Planning
FSI	Fragile States Index
GAP	Gender Action Plan
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GE	Gender Equality
GEWE	Gender Equality and Women's Empowerment
GFCF	Gross Fixed Capital Formation
GII	Gender Inequality Index
GNI	Gross National Income
GPI	Gender Parity Index
HDI	Human Development Index
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immuno-Deficiency Syndrome
ICPD	International Conference on Population and Development
ICTY	The International Criminal Tribunal for the former Yugoslavia
ILO	International Labour Organisation
IMF	International Monetary Fund
IOM	International Organisation for Migrations
IRC	Interreligious Council
JP	Joint Programme
JWP	Joint Work Plan
KM	Bosnian currency Convertible Mark
LFS	Labour Force Survey
MDGs	Millennium Development Goals
MISP	Minimum Initial Service Package
MICS	Multiple Indicator Cluster Survey
MIPAA	Madrid International Plan of Action on Ageing
MISP	Minimum Initial Services Package
MP	Member of Parliament
M&E	Monitoring and Evaluation
NA	Not available
NATO	North-Atlantic Treaty Organisation
NGO	Non-Governmental Organisation
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
OSRS	Obstetric and Response Surveillance System
PD	Population Dynamics/and Development
PPH	Partnership for Public Health
PPP	Purchasing Power Parity
PwD	Persons with Disability

RMP	Resource Mobilisation Plan
RO	Regional Office
RS	Republika Srpska
SAQ	Self-Administered Questionnaire
SDGs	Sustainable Development Goals
SFRY	Socialist Federal Republic of Yugoslavia
SMEs	Small and Medium Enterprises
SOP	Standard Operating Procedures
SP	Strategic Plan
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STDs/STIs	Sexually Transmitted Diseases/Sexually Transmitted Infections
TMA	Total Market Approach
ToR	Terms of Reference
ToT	Training of Trainers
UK FCO	United Kingdom Foreign & Commonwealth Office
UN	United Nations
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDESA	United Nations Department of Economic and Social Affairs
UNDP	United Nations Development Programme
UNECE	United Nations Economic Commission for Europe
UNEG	United Nations Evaluation Group
UNEP	United Nations Environment Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
UNODC	United Nations Office on Drugs and Crime
UN SC	United Nations Security Council
UNSCR	United Nations Security Council Resolution
UNV	United Nations Volunteers
UN-Women	The United Nations Entity for Gender Equality and the Empowerment of Women
UPR	Universal Periodical Review
USK	Una-Sana Canton
WB	World Bank
WHO	World Health Organisation
WP	Work Plan
YERP	Youth Employability and Retention Project
ZDK	Zenica-Doboj Canton

Key Facts

	BiH	FBiH	RS	BD
Demography				
Population thousands (2013) ¹	3,531,159	2,219,220	1,170,342	83,516
Urban population in thousands (2013) ²	1,506,691	961,617	NA	45,516
Number of women (2013) ³	1,798,889	1,131,227	598,530	42,266
Number of men (2013) ⁴	1,732,270	1,087,993	571,812	41,250
Young people 15-29 y.o. (2013) ⁵	723,116	476,986	212,931	15,988
Children 0-14 y.o. (2013) ⁶	543,719	356,948	164,807	13,081
Natural Increase Rate (2016)	-1.8‰ ⁷	-0.7‰ ⁸	-3.9‰ ⁹	-1.3‰ ¹⁰
Population Growth Rate (2017)	-0.3% ¹¹	NA	NA	NA
Change in working age population (15-64 y.o.) 2013-2017 ¹²	-252,000	-180,000	-32,754 ¹³	
Change in 65+ population 2013-2017 ¹⁴	61,000	39,000	22,204 ¹⁵	2,000
Life expectancy at birth	77 ¹⁶ (est. 2015-2020)	76.8 ¹⁷ (2017)	77.2 ¹⁸ (2017)	NA
SDG.3.2.1.: Under-five mortality rate (per 1000 live births)	5.7 ¹⁹ (2017)	9.1 ²⁰ (2017)	3.4 ²¹ (2016)	0 ²²
Infant mortality rate (per 1000 live births)	4.9 ²³ (2017)	8.2 ²⁴ (2017)	2.4 ²⁵ (2016)	0 ²⁶
Total number of deaths due to road traffic injuries	321 ²⁷ (2016)	188 ²⁸ (2016)	126 ²⁹ (2016)	NA
Economy				
GDP per capita PPP current international US\$ (2017)	\$13,107.72 ³⁰			
GDP Real Growth rate (2017)	3.4% ³¹	3.2% ³²	3.1% ³³	NA
Government consumption, % of GDP (2017)	19.8% ³⁴	NA	21.2% ³⁵	NA
Gross fixed capital formation (2017)	17.5% ³⁶	16% ³⁷	21.8% ³⁸	NA
Unemployment rate (2018) ^{39 40}	18.4%	19.2%	17.2%	(19.8%)
Unemployment rate, men (2018)	17.2%	17.8%	16.3%	18.3%
Unemployment rate, women (2018)	20.3%	21.5%	18.5%	(22.5%)
Unemployment rate, 15-24 y.o. (2018)	39.1%	41.4%	35.2%	NA ⁴¹
Unemployment rate, men 15-24 y.o. (2018)	35.6%	40%	(29.8%)	NA
Unemployment rate, women 15-24 y.o. (2018)	46%	44%	48%	NA
Activity rate, men (2018)	53.2%	51.1%	56.9%	50.6%
Activity rate, women (2018)	31.4%	28.7%	36.5%	28.4%
Activity rate, men 15-24 y.o. (2018)	40.3%	38.5%	44.2%	NA
Activity rate, women 15-24 y.o. (2018)	23.1%	23.4%	(22.3%)	NA
% of employed men who are unpaid family workers (2018)	(1.9%) [‡]	NA	(3.8%)	NA
% of employed women who are unpaid family workers (2018)	(6.8%)	((1.7%))	(13.9%)	NA
% of employed men who are self-employed (2018)	19.6%	16.2%	23.9%	(31.3%)
% of employed women who are self-employed (2018)	14.3%	(10.4%)	19%	((26.8%))
Social indicators				
Human Development Index Rank (2018)	0.768 ⁴²			
Distribution of Family Income - Gini Index (2015) ⁴³	29	28.9	28.9 ⁴⁴	29.4
Households living in poverty (2015) ⁴⁵	170,619	104,666	49,805 ⁴⁶	3,452

[‡] Data points enclosed in parantheses () indicate a less precise estimate. Data points enclosed in double parantheses (()) indicate an imprecise estimate.

Population below national poverty line (2015) ⁴⁷	16.9%	17.1%	12.8% ⁴⁸	17.6%
Net enrolment rate, primary (2011) ⁴⁹	97.6%	97.2%	98.9%	89.9%
SDG.4.5.1.: Gender Parity Index (net enrolment ratio in primary school) (2011) ⁵⁰	0.99	0.99	1.00	1.12
Total illiteracy rate (2013) ⁵¹	2.82%	2.63%	3.29% ⁵²	2.83%
Health expenditure as % of GDP (2016)	9.4% ⁵³	8.4% ⁵⁴	11.7% ⁵⁵	NA
SDG.9.5.1.: Research and development expenditure as a proportion of GDP	0.21% ⁵⁶ (2015)	0.05% ⁵⁷ (2017)	0.17% ⁵⁸ (2017)	NA
Reproductive and maternal health indicators				
SDG.3.1.1.: Maternal mortality ratio (per 100,000 live births)	0 ⁵⁹ (2016) [est. 11 ⁶⁰ (2015)]	0 ⁶¹ (2017)	0 ⁶² (2017)	0 ⁶³ (2017)
SDG.3.1.2.: Proportion of births attended by skilled health personnel	99.9% ⁶⁴ (2015)	99.9% ⁶⁵ (2017)	99.9% ⁶⁶ (2017)	NA
Contraceptive prevalence (% of women ages 15-49) (2012) ⁶⁷	45.8%	43.1%	53.7%	24.7%
Unmet need for family planning (2012) ⁶⁸	9% of married women 15-49	9.9%	6.7%	13.1%
Total fertility rate	1.3 ⁶⁹ (2016)	1.3 ⁷⁰ (2017)	1.3 ⁷¹ (2017)	NA
SDG.3.7.2.: Adolescent birth rate (births per 1000 women aged 15-19)	11 ⁷² (2016)	11.4 ⁷³ (2017)	9.5 ⁷⁴ (2017)	NA
Number of abortions	NA	2,280 ⁷⁵ (2017) (public sector)	2,038 ⁷⁶ (2016)	NA
Number of abortions per 1,000 live births	NA	118.7 ⁷⁷ (2017) (public sector)	214.9 ⁷⁸ (2016)	NA
Women <19 y.o. as a share of all women who had an abortion	NA	NA	1.4% ⁷⁹ (2016)	NA
HIV prevalence	<0.1% ⁸⁰ (2011)	NA	0.4% ⁸¹ (2017)	NA
Gender equality indicators				
Illiteracy rate - men ⁸² ⁸³ (2013)	0.8%	0.7%	0.9%	1%
Illiteracy rate – women (2013)	4.8%	4.5%	5.5%	4.5%
Proportion of male population with incomplete or no basic education (2013)	7.4%	6.6%	8.8%	9.8%
Proportion of female population with incomplete or no basic education (2013)	20.4%	19.9%	21.8%	20.3%
Proportion of male education with completed primary education (2013)	18.9%	18.4%	19.6%	23.8%
Proportion of female population with completed primary education (2013)	23.9%	24.6%	22.6%	27.5%
Proportion of male population with completed secondary education (2013)	59.5%	60.5%	57.6%	54.8%
Proportion of female population with completed secondary education (2013)	43%	42.3%	43.9%	41.9%
Proportion of male population with completed tertiary education (2013)	13%	13.3%	14%	10.8%
Proportion of female population with completed tertiary education (2013)	12.4%	13%	11.7%	10.1%
% of seats held by women in parliament (2014) ⁸⁴	19.9% (state total), 23.81% (state level)	21.43%	15.66%	NA
Share of women ministers [§]	22% ⁸⁵ (2018)	25% ⁸⁶	37.5% ⁸⁷ (2019)	NA
Share of women mayors	4% ⁸⁸ (2016)	1.3% ⁸⁹ (2016)	7.8% ⁹⁰ (2017)	NA

[§] The calculation for BiH includes the position of Chair of the Council of Ministers, while calculations for FBiH and RS do not include positions of prime ministers.

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- ¹ Population for Bosnia and Herzegovina, the entity Federation of Bosnia and Herzegovina, and District Brčko were taken from the 2013 Census results as reported by the Agency for Statistics of Bosnia and Herzegovina on www.statistika.ba (Agency for Statistics of Bosnia and Herzegovina, 2018a), retrieved 2018. Population data for the entity Republika Srpska is taken from the publication “Census Results” by the Republika Srpska Institute of Statistics. *Rezultati popisa: gradovi, opštine, naseljena mjesta* (Republika Srpska Institute of Statistics, 2017a).
- ² Ibid.
- ³ Ibid.
- ⁴ Ibid.
- ⁵ Ibid.
- ⁶ Ibid.
- ⁷ *Demography and Social Statistics. World Population Day* (Agency for Statistics of Bosnia and Herzegovina, 2018b)
- ⁸ *Statistical Yearbook* (Institute for Statistics of FBiH, 2017a)
- ⁹ *Statistical Yearbook* (Republika Srpska Institute of Statistics, 2017b)
- ¹⁰ *Demografija u Brčko Distriktu BiH 2013-2017. godina* (Agency for Statistics of Bosnia and Herzegovina, 2018c)
- ¹¹ *Births attended by skilled health staff (% of total)* (The World Bank Group, 2019a)
- ¹² Data for Bosnia and Herzegovina, the entity Federation of Bosnia and Herzegovina and District Brčko are calculated based on estimates from the annual Labour Force Surveys: *Labour Force Survey 2015. Final Results* (Agency for Statistics of Bosnia and Herzegovina, 2015), *Labour Force Survey 2017* (Agency for Statistics of Bosnia and Herzegovina, 2017b)
- ¹³ Data provided by the Republika Srpska Institute of Statistics. Internal correspondence 22/05/2019.
- ¹⁴ Ibid.
- ¹⁵ Data provided by the Republika Srpska Institute of Statistics. Internal correspondence 22/05/2019.
- ¹⁶ *World Population Prospects: The 2015 Revision, Key Findings and Advance* (United Nations, 2015a)
- ¹⁷ *Abbreviated Approximate Life Tables, Federation of Bosnia and Herzegovina, 2017* (Institute for Statistics of FBiH, 2018a)
- ¹⁸ *Demographic Statistics* (Republika Srpska Institute of Statistics, 2018a)
- ¹⁹ *Mortality rate, under -5 (per 1,000 live births)* (The World Bank Group, 2019b)
- ²⁰ *Demographics 2017* (Institute for Statistics of FBiH, 2018b)
- ²¹ *Statistical Yearbook* (Republika Srpska Institute of Statistics, 2017b)
- ²² *Demografija u Brčko Distriktu BiH 2013-2017. godina* (Agency for Statistics of Bosnia and Herzegovina, 2018c)
- ²³ *Mortality rate, infant (per 1,000 live births)* (The World Bank Group, 2019c)
- ²⁴ *Demographics 2017* (Institute for Statistics of FBiH, 2018b)
- ²⁵ *Analysis of Population Health in Republic of Srpska 2016* (Public Health Institute, Republic of Srpska, 2017)
- ²⁶ *Demografija u Brčko Distriktu BiH 2013-2017. godina* (Agency for Statistics of Bosnia and Herzegovina, 2018c)
- ²⁷ *Sustainable Development Indicators. Bosnia and Herzegovina* (Agency for Statistics of Bosnia and Herzegovina, 2017a)
- ²⁸ *Statistical Yearbook* (Institute for Statistics of FBiH, 2017a)
- ²⁹ *Statistical Yearbook* (Republika Srpska Institute of Statistics, 2017b)
- ³⁰ *World Bank Open Data* (The World Bank Group, 2019d)
- ³¹ *First Release. Gross Domestic Product by Expenditure Approach 2007-2017* (Agency for Statistics of Bosnia and Herzegovina, 2018d)
- ³² *Statistical Yearbook 2018* (Institute for Statistics of FBiH, 2018c)
- ³³ *Statistical Yearbook of Republika Srpska 2018* (Republika Srpska Institute of Statistics, 2018b)
- ³⁴ *First Release. Gross Domestic Product by Expenditure Approach 2007-2017* (Agency for Statistics of Bosnia and Herzegovina, 2018d)
- ³⁵ *National Accounts* (Republika Srpska Institute of Statistics, 2018c)
- ³⁶ *First Release. Gross Domestic Product by Expenditure Approach 2007-2017* (Agency for Statistics of Bosnia and Herzegovina, 2018d)
- ³⁷ Data provided by the Institute for Statistics of FBiH. Calculated based on figures for GFCF and GDP in *Gross Fixed Capital Formation 2017* (Institute for Statistics of FBiH, 2018d) and *Statistical Yearbook 2018* (Institute for Statistics of FBiH, 2018c).
- ³⁸ *National Accounts* (Republika Srpska Institute of Statistics, 2018c)

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- ³⁹ All economic activity, employment and unemployment data listed for Bosnia and Herzegovina, the entity Federation of Bosnia and Herzegovina, and District Brcko is from *Labour Force Survey 2018* (Agency for Statistics of Bosnia and Herzegovina, 2018f)
- ⁴⁰ All economic activity, employment and unemployment data listed for the entity Republika Srpska is from *Labour force survey 2018* (Republika Srpska Institute of Statistics, 2018f)
- ⁴¹ While all data in the LFS is generally disaggregated to show estimates for Brcko District separately from the two entities, the number of observations in Brcko District, as per sampling methodology, is too small to estimate some proportions, or they are estimated with much less precision than for FBiH and RS. The proportions not reported here are either not reported in the LFS or they are reported as small with a wide confidence interval.
- ⁴² *Human Development Indices and Indicators: 2018 Statistical Update, Bosnia and Herzegovina* (UNDP, 2018)
- ⁴³ Data for Bosnia and Herzegovina, the entity Federation of Bosnia and Hezegovina and District Brcko is from *First Release. Demographic and Social Statistics. Household Budget Survey 2015* (Agency for Statistics of Bosnia and Herzegovina, 2017c)
- ⁴⁴ (Republika Srpska Institute of Statistics, 2018e)
- ⁴⁵ Data for Bosnia and Herzegovina, the entity Federation of Bosnia and Hezegovina and District Brcko is from *Household Budget Survey 2015* (Agency for Statistics of Bosnia and Herzegovina, 2018e)
- ⁴⁶ *Republika Srpska Sustainable Development Indicators* (Republika Srpska Institute of Statistics, 2018e)
- ⁴⁷ Data for Bosnia and Herzegovina, the entity Federation of Bosnia and Hezegovina and District Brcko is from *Household Budget Survey 2015* (Agency for Statistics of Bosnia and Herzegovina, 2018e)
- ⁴⁸ *Republika Srpska Sustainable Development Indicators* (Republika Srpska Institute of Statistics, 2018e)
- ⁴⁹ *Bosnia and Herzegovina Mutiple Indicators Cluster Survey (MICS) 2011-2012* (Agency for Statistics of Bosnia and Herzegovina; Federal Ministry of Health; Ministry of Health and Social Welfare of Republika Srpska; Institute of Public Health FB&H; UNICEF, 2013)
- ⁵⁰ Ibid.
- ⁵¹ Retrieved 2018 from Census 2013 in Bosnia and Herzegovina: www.statistika.ba (Agency for Statistics of Bosnia and Herzegovina, 2018a)
- ⁵² *Rezultati popisa: gradovi, opštine, naseljena mjesta* (Republika Srpska Institute of Statistics, 2017a)
- ⁵³ *First Release. Demography and Social Statistics. National Health Accounts Statistics* (Agency for Statistics of Bosnia and Herzegovina, 2016a)
- ⁵⁴ Data provided by the Institute for Statistics of FBiH. Calculated based on figures in *National Health Accounts Statistics in Federation of BiH 2016* (Institute for Statistics of FBiH, 2018e) and *Statistical Yearbook* (Institute for Statistics of FBiH, 2017a).
- ⁵⁵ *Health Statistics. Annual Release. Health Expenditure 2016* (Republika Srpska Institute of Statistics, 2018d)
- ⁵⁶ *Sustainable Development Indicators. Bosnia and Herzegovina* (Agency for Statistics of Bosnia and Herzegovina, 2017a)
- ⁵⁷ Data provided by the Institute for Statistics of FBiH. Calculated based on figures in *First Release. Government Budget Appropriations or Outlays for R&D, 2017-2018* (Institute for Statistics of FBiH, 2018f) and *Statistical Yearbook 2018* (Institute for Statistics of FBiH, 2018c).
- ⁵⁸ Calculated based on research and development expenditure in the Republic of Srpska reported in *Research and Development 2017* (Republika Srpska Institute of Statistics, 2018g)
- ⁵⁹ *Demography 2016* (Agency for Statistics of Bosnia and Herzegovina, 2017d)
- ⁶⁰ *Trends in Maternal Mortality: 1990-2015* (WHO, UNICEF, UNFPA, World Bank Group, and the UN Population Division, 2015)
- ⁶¹ *Demographics 2017* (Institute for Statistics of FBiH, 2018b)
- ⁶² *Demographic Statistics* (Republika Srpska Institute of Statistics, 2018a)
- ⁶³ *Demografija u Brčko Distriktu BiH 2013-2017. godina* (Agency for Statistics of Bosnia and Herzegovina, 2018c)
- ⁶⁴ *Births attended by skilled heath staff (% of total)* (The World Bank Group, 2019e)
- ⁶⁵ *Demographics 2017* (Institute for Statistics of FBiH, 2018b)
- ⁶⁶ *Demographic Statistics* (Republika Srpska Institute of Statistics, 2018a)
- ⁶⁷ *Bosnia and Herzegovina Mutiple Indicators Cluster Survey (MICS) 2011-2012* (Agency for Statistics of Bosnia and Herzegovina; Federal Ministry of Health; Ministry of Health and Social Welfare of Republika Srpska; Institute of Public Health FB&H; UNICEF, 2013)
- ⁶⁸ Ibid.
- ⁶⁹ *Demography 2016* (Agency for Statistics of Bosnia and Herzegovina, 2017d)
- ⁷⁰ *Zdravstveno stanje stanovništva i zdravstvena zaštita u Federaciji Bosne i Hercegovine. 2017. godina* (Institute for Public Health FBiH, 2018)
- ⁷¹ *Republika Srpska Sustainable Development Indicators* (Republika Srpska Institute of Statistics, 2018e)
- ⁷² *Demography 2016* (Agency for Statistics of Bosnia and Herzegovina, 2017d)

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- ⁷³ *Statistical Yearbook* (Institute for Statistics of FBiH, 2017a)
- ⁷⁴ Calculated based on data on live births, still births, and population estimates in 2017 from *Demographic Statistics* (Republika Srpska Institute of Statistics, 2018a). Verified by the Ministry of Health and Social Welfare of Republic of Srpska.
- ⁷⁵ *Zdravstveno stanje stanovništva i zdravstvena zaštita u Federaciji Bosne i Hercegovine. 2017. godina* (Institute for Public Health FBiH, 2018)
- ⁷⁶ *Analysis of Population Health in Republic of Srpska 2016* (Public Health Institute, Republic of Srpska, 2017)
- ⁷⁷ *Zdravstveno stanje stanovništva i zdravstvena zaštita u Federaciji Bosne i Hercegovine. 2017. godina* (Institute for Public Health FBiH, 2018)
- ⁷⁸ *Analysis of Population Health in Republic of Srpska 2016* (Public Health Institute, Republic of Srpska, 2017)
- ⁷⁹ Ibid.
- ⁸⁰ *Strategija za odgovor na HIV i AIDS u Bosni i Hercegovini 2011-2016* (Council of Ministers of Bosnia and Herzegovina, 2011)
- ⁸¹ *Analysis of Population Health in Republic of Srpska 2017* (Public Health Institute, Republic of Srpska, 2018)
- ⁸² All data on illiteracy rate and educational attainment for Bosnia and Herzegovina, the entity Federation of Bosnia and Herzegovina, and District Brčko is from Census 2013 retrieved from [www. statistika.ba](http://www.statistika.ba) in 2018 (Agency for Statistics of Bosnia and Herzegovina, 2018a)
- ⁸³ All data on illiteracy rate and educational attainment in the entity Republika Srpska are from *Rezultati popisa: gradovi, opštine, naseljena mjesta* (Republika Srpska Institute of Statistics, 2017a)
- ⁸⁴ *Politička participacija žena u Bosni i Hercegovini: Analiza učešća žena na stranačkim listama i konačnih rezultata općih izbora 2014* (Miftari, 2015)
- ⁸⁵ Calculated based on publicly available information. Validated by the Agency for Statistics of Bosnia and Herzegovina. Internal correspondence 15/02/2019.
- ⁸⁶ Calculated based on publicly available information. Validated by the Agency for Statistics of Bosnia and Herzegovina. Internal correspondence 15.02.2019.
- ⁸⁷ Calculated based on publicly available information. Validated by Republika Srpska Institute of Statistics. Internal correspondence 14/02/2019.
- ⁸⁸ Data provided by the Agency for Statistics of Bosnia and Herzegovina. Internal correspondence 15/02/2019.
- ⁸⁹ Calculated based on information published in *Lokalni izbori 2016 - Potvrđeni rezultati - Načelnik/gradonačelnik* (Central Election Commission Bosnia and Herzegovina, 2016)
- ⁹⁰ Data provided by Republika Srpska Institute of Statistics. Calculated based on *Statistical Yearbook of Republika Srpska 2018* (Republika Srpska Institute of Statistics, 2018b) and Central Election Commission data.

Executive Summary

Overview: The Bosnia and Herzegovina (BiH) Country Programme Evaluation forms a constituent part (country case study) of the Cluster Programme Evaluation of the programmes of UNFPA offices in BiH, the Republic of North Macedonia, the Republic of Serbia, and Kosovo, which is planned as part of the UNFPA quadrennial evaluation plan (DP/FPA/2018/1) approved by the Executive Board. The Cluster Programme Evaluation will permit the identification of common higher-level findings that can inform future UNFPA activities. The overall purpose of the Country/territory Programme Evaluation (CPE) is to: a) demonstrate accountability to stakeholders on performance in achieving development results and on invested resources, b) support evidence-based decision-making, and c) contribute important lessons learned to the existing knowledge base on how to accelerate the implementation of the International Conference on Population and Development (ICPD) Programme of Action.

Objectives and scope: The CPE covers activities planned and/or implemented during the period 2013-2018 in Bosnia and Herzegovina, within each programme component: sexual and reproductive health and rights (hereinafter: SRHR), adolescents and youth (hereinafter: Youth), population dynamics (hereinafter: PD), gender equality (hereinafter: GE), and cross-cutting areas: partnership, resource mobilization, and advocacy. The frameworks for the CP (2010-2014, 2015-2019(20)) had three and four outcomes, respectively, and a varying number of outputs. These were the central focus of the evaluation. Attention was given to key activities related to the outcomes and outputs, in particular, whether or not these key activities were completed satisfactorily or not. The specific objectives of this evaluation are: a) to provide an independent assessment of the progress towards the expected outputs and outcomes set forth in the results framework of the country programme (CP); b) to provide an assessment of the Country Office (CO) positioning within the developing community and national partners, in view of its ability to respond to national priority needs while adding value to the development results; and c) draw key lessons from past and current cooperation and provide a set of clear, specific and action-oriented strategic recommendations for the next programming cycle.

Methodology: This evaluation is designed to review CP using two separate evaluation components: Component 1: Analysis of the programme's Outcomes, Outputs and activities by the four main focus areas that reflect alignment to the global UNFPA Strategic Plans 2014-2017, 2018-2021 - SRHR, Youth, GE, and PD, and Component 2: Analysis of CO's coordination within the UN Country Team (UNCT) and among national partners in the four focus areas as well as the CO's added value. The evaluation criteria for Component 1 include: relevance, effectiveness, efficiency and sustainability. Evaluation questions have been central to the conduct of the evaluation. A detailed evaluation matrix has been prepared which explains which data sources and methods have been used to address each of these questions. A mixed method approach was selected in order to ensure triangulation of information from different sources. The primary sources for this CPE were: documentary sources (CP documents and assessments), stakeholder interviews, and trainee and beneficiary interviews. The limitations of evaluation include the fact that due to limited time and resources it was not feasible to collect representative samples. An attempt was made to avoid bias of sources by triangulation of data. All interviews outside UNFPA were conducted without presence of UNFPA staff, and interviews with UNFPA staff were conducted individually.

Main conclusions:

Strategic level conclusions

UNFPA has delivered most planned interventions within the existing focus areas at the level of outputs. These outputs have been delivered with limited resources and the use of resources has generally been efficient. It was found that more lasting effects could have been achieved with a focus on fewer outputs and a longer-term vision for embedding results into domestic regulation and practices. The work across four fully-fledged programmatic areas and on a large number of activities has demanded significant managerial, substance-related, and administrative efforts of a small and not always constant number of staff. Given the human and financial resources, as well as limited fundraising policies, UNFPA's target setting in the Country Program Document (CPD) needs to be more informed, realistic and clear.

UNFPA has contributed to creation of several policies and procedures for different population groups, or population-related issues, but there is limited evidence that sufficient attention has been paid to vulnerable and marginalized groups. UNFPA has a specific mandate, which has minimized the risk of overlap with other UN or other programmes. This mandate should be exploited by placing more focus on interventions that are exclusively parts of the UNFPA core mandate, and in line with the ICPD and SDG agenda.

Programmatic level conclusions

SRHR - UNFPA CP has been aligned with international and domestic policy frameworks and the needs of individual target groups, mostly women. UNFPA CP has contributed to creating key underlying assumptions for increased utilization of integrated SRHR services, including family planning, procedures for maternal health and monitoring maternal mortality and morbidity, although not focusing on those furthest behind. Results achieved in Family Planning repositioning are reflected largely in delivery of trainings and should be followed up to ensure full procedural embedding, continuous training, monitoring and evaluation. The unique position of primary health care providers should be tested for embedding of additional SRHR services, including prevention of STIs, HIV, and systemic reproductive organ cancer screening. There is room for better outreach to marginalized and vulnerable groups, including youth, Roma, and people at risk of HIV infections. Revised domestic SRH policies are expected to be adopted and their implementation will require support. Research into causes of maternal morbidity and mortality, including that of marginalized and vulnerable groups of women, remains pertinent. UNFPA's direct emergency response during floods and migrant crisis has provided a clear evidence base for integration of the Minimal Initial Service Package (MISP) into preparedness plans, which needs to be further promoted.

Youth - UNFPA CP has been aligned with international youth policy frameworks and the needs of youth in general, but there is limited evidence that national policy frameworks and the changing local context have shaped the CP. Existing and new domestic policies in the area of Youth as well as major changes in the local context, such as youth emigration, need to be consulted regularly and interventions should be planned accordingly. Needs of specific vulnerable and marginalized groups need to be examined carefully, particularly those of girls and at-risk youth populations. UNFPA interventions related to sexuality education could gradually lead to increased access of young people to sexuality education. The Comprehensive Sexuality Education (CSE) coverage in BiH is limited to two cantons only, which is far from sufficient. Interventions need to expand in order to ensure wider CSE coverage and increased access to sexuality education. Youth friendly approaches to provision of SRHR services are still in a nascent phase and their effects are yet to be tested. Ways to reach marginalized and particularly vulnerable groups of youth in terms of sexuality education and access to SRHR services need to be identified.

GE - UNFPA CP in the GE programmatic area has been mostly aligned with international and national policy frameworks and adapted to the local context; the CP has been adapted largely to the needs of women, including some groups of marginalized and vulnerable women, more specifically victims of GBV and Conflict-Related Sexual Violence (CRSV). Mainstreaming of provisions to advance gender equality has been achieved to a good extent. Integration of GBV prevention, protection and response into national sexual and reproductive health programmes is evidence of successful gender mainstreaming. The implementation of practices related to GBV prevention, protection and response into national sexual and reproductive health programmes as yet remains to be measured. The same can be argued for integration of stigma alleviating practices. Gender transformative actions, such as the work carried out in cooperation with BiH Women's Football Team are also evidence of good gender mainstreaming and this success should be replicated in other spheres of social life, with a view of further analysing and addressing gender stereotypes.

PD - UNFPA CP is mostly aligned with international and national population policy frameworks and the needs of specific population groups, most notably older persons and the migrant population. There is room for a more comprehensive approach to other population groups, including different marginalized groups in order to integrate the issue of social exclusion into rights-based population

policies. Developing of evidence-based national population policies has been achieved to a good extent. The successes result mostly from drafting of policies for older persons, youth and SRHR, as well as development of a migration monitoring methodology. However, in this component UNFPA has not been able to rely on, or generate sound data, in order to help domestic institutions use this data for population policy making. There is need for UNFPA, as an agency with a specific population-related mandate, to maximize its role in direct data collection as well as support to domestic institutions in the development of sound methodologies for data collection, in line with international standards, including ICPD and SDGs requirements.

UNCT Coordination and Added Value - UNFPA CO has made consistent positive contributions to the consolidation and functioning of the UNCT coordinating mechanisms (results groups, task forces and joint programmes) toward implementation of the UNDAF in each of the four program areas. UNFPA has cooperated with other UN agencies in delivery of activities and programmes, but there is inconclusive evidence on programme complementarity, seeking synergies and avoiding overlaps and duplication of activities among development partners. Stakeholders said that UNFPA added value in multiple areas within the country context, and these areas are primarily the SRHR and PD.

Main recommendations:

Strategic level recommendations

UNFPA should consider streamlining its work into two programme areas, SRHR and PD, to capitalize on its core mandates and biggest added values as recognized by stakeholders, while ensuring focus on selected target groups in line with the UNFPA Strategic Plan and local needs. The two components of focus should be on SRHR and PD, with mutual links and synergies established between them for capacity development, knowledge management and advocacy for policy solutions. A decision could be made to focus only on one target group (most notably, youth), or more, depending on available resources.

In its future programme, UNFPA needs to continue coordinating its programmatic actions with UN agencies and other partners (including EU, bilateral donors and their implementing partners) in order to avoid duplication and overlap. UNFPA should keep and regularly update a comprehensive stakeholder register with identified interests and influence of each stakeholder in order to foster partnerships and ensure regular processes of stakeholder management, including required communication and engagement.

UNFPA needs to capitalize on its comparative advantage of expertise in SRHR (including CSE and GBV in emergencies) and PD, as well as actions for adolescent girls and gender transformative actions (as part of initiatives targeting youth).

UNFPA should continue the practice of integrating internationally developed methodologies in BiH and the practice of bringing in international know how, standards and best practices should be maintained.

UNFPA should decide which interventions have the biggest potential for long-term development, introducing systemic solutions, which are feasible and could have the necessary buy in from domestic partners, and pursue these interventions. UNFPA should engage in a robust and rigorous planning exercise, which will result in setting of 3-4 long-term goals in line with the UNFPA Strategic Plan and local needs (most notably, increased youth knowledge of SRHR, increased access of young people to SRH services, changed perception of gender role among youth, increased knowledge of reasons behind youth emigration and policy recommendations, among other possible goals). Sufficient time and resources need to be invested in monitoring and reporting on implementation of work plans, as well as resource mobilization, partnership and advocacy plans.

Programmatic level recommendations

The recommendations given should be considered as a list of options and selected for implementation based on resources available and prioritization of needs in line with the domestic policies, needs and

established partnerships. Recommendations are given for all four CP components, although it is recommended above, under strategic recommendations, that the CP be reduced to two components. In line with this strategic recommendation, different levels of priority are suggested. The recommendations given the highest priority are related to SRHR and PD in relation to the specific target group of youth.

Priorities of high level:

1. UNFPA should adjust its interventions to the needs of specific groups of populations, including marginalized and vulnerable groups, and develop tailor-made interventions for these groups. UNFPA should design specific modules for service provision for marginalized or vulnerable groups, including primarily youth and sub-categories of youth, and plan for specific outreach activities.
2. UNFPA should continue to work on embedding CSE in the school curricula in FBiH and RS. UNFPA should capitalize on the results achieved so far, based on the lessons learned, to avoid excessive costs. This could entail replication of the training materials for primary school teachers and investing in development of curriculum and training materials for secondary schools.
3. UNFPA should help relevant institutions implement priorities related to sexuality education and SRHR services from FBiH and RS strategic documents for improvement of sexual and reproductive health and rights. UNFPA should assess which is the best way to offer SRHR services to young people, by taking stock of the lessons learned through the Global Fund programme, other initiatives, as well as its own family planning repositioning interventions.
4. UNFPA should focus on the empowerment of girls and transformation of gender roles. UNFPA should design specific interventions to empower girls in line with UNFPA's Action for Adolescent Girls, adjusted to local context.
5. UNFPA should invest targeted effort in surveying the magnitude and reasons for youth emigration and assist domestic authorities in creating evidence-based policies. Research results should be promoted widely and solutions advocated with relevant stakeholders, including partners in UN youth programming.

Priorities of medium level:

6. UNFPA should continue to work on family planning in order to reduce the number of abortions and unmet need. Family planning needs to be embedded more deeply into the primary health care service, as well as promoted more widely among the general public, and among specific subgroups of the population.
7. UNFPA should continue work on introduction of breast, cervical and prostate cancer screening. UNFPA should support partner institutions in analysing the cost of cancer treatment and cancer screening and use this information for advocacy.
8. UNFPA should continue to work on the integration of MISP into health sector's response to emergencies, and the prevention and response to GBV in emergencies. UNFPA should assess what remains to be done for systemic integration of minimal standards into preparedness plans in terms of regulatory, institutional and organization framework, including ensuring that there are sufficient trained individuals and sufficient supplies.
9. UNFPA should embed GBV and CRSV response training into training programmes for health professionals and monitor the application of these procedures. Innovative ways of training delivery could be explored, e.g. online training modules, which would be endorsed by institutions in charge of medical training and certifications.
10. UNFPA should contribute to better population data collection. UNFPA should plan and implement specific, but smaller scale data collection activities to help relevant institutions avail themselves of reliable information on demographics, including migration, and health. Along with this, UNFPA should take an active part in translating the SDGs that are pertinent to its mandate into the domestic context and promoting the ICPD agenda and relevant data collection, in coordination with other UN agencies.

Priorities of low level:

11. UNFPA should continue to work on maternal mortality and morbidity surveillance. Although BiH is a country with low maternal mortality, UNFPA should continue to support introduction of a system for surveillance of and research into causes of maternal mortality and morbidity that is adapted to the local context, at least at the level of pilot institutions that have already been approached.

12. UNFPA should follow up on its work to alleviate stigma against GBV and CRSV victims by delivering focused, yet comprehensive, solutions. UNFPA should identify, based on its experience and lessons learned so far, who are the most influential opinion-makers among the general public and engage in focused activities for the alleviation of stigma against victims of GBV and CRSV.

13. UNFPA should support monitoring of policies for SRHR, youth and ageing and advocate further drafting of comprehensive population policies. UNFPA should support domestic institutions in developing and implementing robust monitoring of existing and future policies created with the help of UNFPA.

CHAPTER 1: Introduction

1.1. Purpose and objectives of the Programme Evaluation

Bosnia and Herzegovina (BiH) is one of UNFPA country offices (CO), which, together with the Republic of North Macedonia, the Republic of Serbia, and Kosovo, forms one of the administrative clusters of the Eastern Europe and Central Asia (EECA) region. The CO is implementing the programme cycle extending through 2020.

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

The specific objectives of this evaluation are: a) to provide an independent assessment of the progress towards the expected outputs and outcomes set forth in the results framework of the country programme (CP); b) to provide an assessment of the CO positioning within the developing community and national partners, in view of its ability to respond to national priority needs while adding value to the development results; and c) draw key lessons from past and current cooperation and provide a set of clear, specific and action-oriented strategic recommendations for the next programming cycle.

The BiH Programme Evaluation forms a constituent part (country case study) of the Cluster Programme Evaluation of the programmes of UNFPA offices in BiH, the Republic of North Macedonia, the Republic of Serbia, and Kosovo, which is planned as part of the UNFPA quadrennial evaluation plan (DP/FPA/2018/1) approved by the Executive Board. The Cluster Programme Evaluation will permit the identification of common higher-level findings that can inform future UNFPA activities.

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

1.2. Scope of the evaluation

The CPE covers activities planned and/or implemented during the period 2013-2018 in Bosnia and Herzegovina, within each programme component: sexual and reproductive health and rights (hereinafter: SRHR), adolescents and youth (hereinafter: Youth), population dynamics (hereinafter: PD), gender equality (hereinafter: GE), and cross-cutting areas: partnership, resource mobilization, and advocacy. Humanitarian response has also been viewed as cross cutting at least three of four UNFPA CP focus areas. Two CP cycles have been effectively under evaluation: 2010-2014 and 2015-2019(20). The latest CPE for Bosnia and Herzegovina was conducted in 2013, therefore only one part of the 2010-2014 CP has been covered by this evaluation.

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

The evaluation reconstructed the programme intervention logic and assessed the extent to which the on-going programme has chosen the best possible modalities for achieving the planned results in the current development context. The evaluation also examined the CP for such critical features as relevance, effectiveness, efficiency, sustainability, UN coordination, and added value. The evaluation applied appropriate methodologies, including the UNEG Handbook for Conducting Evaluations of Normative

Work in the UN System⁵ for assessing the equity and vulnerability, gender equality, human rights in development and humanitarian programmes.

1.3. Methodology and process

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

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

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

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

Table 1 CP Evaluation components and evaluation criteria

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

1.3.1. Evaluation Questions and Evaluation Matrix

As outlined in the Cluster Evaluation Terms of Reference (TOR) in Annex 1, a set of questions have been recommended for each of the above evaluation criteria within each of the two evaluation components. These evaluation questions have been central to the conduct of the evaluation. Annex 6 presents, among other methodological tools, the evaluation questions by evaluation component. With few exceptions, the original questions from the Cluster Evaluation TOR have been retained exactly as worded. The wording for some questions was revised to increase clarity while retaining the intent of the TOR.

As required by the evaluation CPE handbook⁶, a detailed evaluation matrix has been prepared which explains which data sources and methods have been used to address each of these questions (see Annex 4).

Focus of the Evaluation: The frameworks for the CP (2010-2014, 2015-2019(20)) had three and four outcomes, respectively, and a varying number of outputs. These were the central focus of the evaluation. Attention was given to key activities related to the outcomes and outputs, in particular, whether or not these key activities were completed satisfactorily or not. But, due to the time and resources available for this evaluation, all of these activities were not assessed at the same level of rigor and detail.⁷

⁵ *UNEG Handbook for Conducting Evaluations of Normative Work in the UN System* (United Nations Evaluation Group Task Force, 2013)

⁶ *Handbook: How to Design and Conduct a Country Programme Evaluation at UNFPA* (UNFPA Independent Evaluation Office, 2013)

⁷ For example, the CPE did not assess the details of some advocacy activities, such as participation of stakeholders in international conferences and trainings, observing of UN days, or individual activities at local level.

Methods overview: The mixed method was selected in order to ensure triangulation of information from different sources. The primary sources for this CPE were: documentary sources (CP documents and assessments), stakeholder interviews, and trainee and beneficiary interviews and focus group discussions. All findings have been confirmed by at least two sources.

The evaluation follows the principles of the UN Evaluation Group's norms and standards (in particular with regard to independence, objectiveness, impartiality and inclusiveness) and has been guided by the UN ethics guidelines for evaluators in accordance with the UNEG's Ethical Guidelines for Evaluation.⁸

Evaluators were expected to operate in an impartial and unbiased manner, giving balanced interpretations of the strengths and weaknesses of programmes. They respect and protect the rights and welfare of human subjects and communities, respect differences in culture, local customs, religious beliefs and practices, personal interaction, gender roles, disability, age and ethnicity, while using evaluation instruments appropriate to diverse cultural settings. Evaluators ensured that all participants are treated as autonomous and free to choose whether or not to participate in the evaluation.

The evaluation was based on five key activities:

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

Stakeholder Involvement: Meetings were held with key stakeholders, in particular, the Evaluation Reference Group (ERG), which was established by the UNFPA Country Office in BiH comprising key programme stakeholders (national governmental and non-governmental counterparts, and the Evaluation Manager from the UNFPA CO). The role of ERG was to review and provide inputs to the CPE, provide feedback to the evaluation design report, facilitate access of evaluators to information sources, and provide comments on the main deliverables and quality of the evaluation.

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

Semi-structured interviews with stakeholders based on the Cluster Evaluation TOR criteria: These interviews were conducted with a consistent set of precautions for informed consent and confidentiality. See attached draft instruments in Annex 6. Regarding the sampling, a purposive and non-random selection of key informants was made with an attempt to achieve a balance according to administrative area (UNFPA has not worked extensively in the Brcko District (BD), therefore stakeholders from BD have not been included in evaluation), focus area and female versus male respondents. In addition, key informants were selected from donor agencies and UN agencies. In relation to the list of 82 stakeholders provided by UNFPA CO, the sample of interviewees make up 69.5% (53.85% of stakeholders at BiH level and those working across the country, 88,24% of RS stakeholders, 54.17% of FBiH stakeholders, and 93.33 of the stakeholders from UN organizations).

⁸ *UNEG Ethical Guidelines for Evaluation* (United Nations Evaluation Group, 2008)

Table 2 Number of stakeholder interviews by administrative area and focus area

	BiH			FBIH			RS			Total		
	F	M	Total	F	M	Total	F	M	Total	F	M	Total
SRHR												
Implementers	1	1	2	1	2	3	7	1	8	9	4	13
Youth												
Implementers	1	1	2	4		4		1	1	5	2	7
GE Implementers	5		5	1	3	4	4		4	10	3	13
PD Implementers	2	3	5		2	2	1	1	2	3	6	9
Total implementers	9	5	14	6	7	13	12	3	15	27	15	42
Donor Agency staff	1		1							1		1
UN Agency staff	4	3	7							4	3	7
UNFPA Staff	5	2	7							5	2	7
Total UN, donor stakeholders	10	5	15							10	5	15
Total stakeholder interviews	19	10	29	6	7	13	12	3	15	37	20	57

Training Follow-up Assessment and FGDs: Participants from specific UNFPA-supported trainings were asked to respond to questionnaires and participate in FGDs (see Annex 6 for methodological tools). With assistance of UNFPA CP and implementing partners, a database was developed for all training events sponsored by the CP in the last four years. A purposive sample of training activities was selected from this database to achieve balance on trainings conducted within the four focus areas (SRHR, Youth, GE and PD) in major training category areas. The minimum target sample size was 20 completed interviews with a reasonable balance across the four focus areas. UNFPA CP in BiH supported larger-scale trainings in three out of four focus areas (SRHR, Youth and GE). The Evaluation Team had planned to interview selected trainees in person and organize FGDs with help of implementing partners, but this was not possible as it proved to be difficult to gather participants in one place. Also, as most trainees are medical doctors, it was difficult to schedule face-to-face meetings with many of them due to their work in shifts and heavy workload during winter. Instead, phone interviews were organized. A discrepancy in the number of interviewees from FBIH and RS can be attributed to generally larger numbers of trainings and participants from FBIH and an additional set of trainings conducted in FBIH, which was not conducted in RS and was related to comprehensive sexuality education in schools.

Table 3 Training follow-up interviews by administrative area and focus area

	FBIH			RS			BiH/Total		
	F	M	Total	F	M	Total	F	M	Total
SRHR	4	1	5	4		4	8	1	9
YOUTH	2	1	3				2	1	3
GE	4	1	5	3		3	7	1	8
PD									0
Total	10	3	13	7	0	7	17	3	20

Client/Beneficiary Interviews and FGDs: Per the CPE Design Report, it was intended for clients/beneficiaries across the four focus areas to be interviewed using a qualitative semi-structured interview questionnaire (see Annex 6 for methodological tools). The Evaluation team attempted to organize client/beneficiary interviews in the focus areas, but only managed to get access to clients/beneficiaries of the Youth and PD components. The sample presented below is a convenience sample, both in terms of topics discussed and selection of participants. The numbers are not representative of either the older persons or youth populations. This is one of limitations of the selected evaluation method.

Instead of interviewing clients/beneficiaries based on semi-structured interview questionnaire, one group of respondents (senior citizens in one of the Healthy Ageing Centres for PD focus area) was asked to complete self-administered questionnaires, filling them out (without stating their names). This was followed by a FGD (see used FGD Guide among methodological tools in Annex 6) as a tool to assess client satisfaction with the services they have received through UNFPA-supported interventions. For the Youth focus area, only a FGD was organized following an adapted FGD guide (see among methodological tools in Annex 6). UNFPA has not worked extensively in the BD, therefore clients from BD have not been included in evaluation.

Table 4 Client/beneficiary interviews and FGDs by region and focus area

	Number of FGDs			Number of FGD participants		
	FBIH	RS	BiH/Total	FBIH	RS	BiH/Total
PD (users of Healthy Ageing Centre, persons aged 60+)	1	0	1	7 (1 M and 6 F)	0	7
YOUTH (students, under the age of 30)	0	1	1	0	7 (4 M and 3 F)	7
Total	1	1	2	7	7	14

1.3.2. Availability assessment, limitations and risks

Limitations and possible biases of the approach: There are several important limitations in the proposed methods. First, due to limited time and resources it was not feasible to collect representative samples. While there was some opportunity for a randomisation process, for example for the training follow-up assessments, all other samples were largely purposive and not truly representative of the target populations of stakeholders and client/beneficiaries. The evaluation is largely qualitative in nature due to the small, non-random sample sizes. There are possible biases in the selection of respondents due to the requirement to select locations on a purposive non-random basis. To avoid the possibility of bias from the presence of UNFPA staff, all interviews were conducted by the evaluator in private without any UNFPA agency staff present. Interviews with UNFPA staff were conducted individually.

To address the issue of a lack of representative samples, the interview data was supplemented with secondary data, such the CO Annual Reports (COARs), Annual Work Plans (AWPs) and other pertinent programme data, including national research studies and assessment documents. The risk of lower than desired response rates did not materialize when it comes to stakeholder interviews. The insufficient availability of trainees for interviews was overcome by phone interviews. Through a process of triangulation, where multiple sources of data were assessed, it was possible to enhance the certainty that the data and information collected are valid. The results from different data collection methods (such as review of documents, interviews, group discussions and FGDs) were assessed for consistency to ensure validity of findings.

Approaches to reduce bias: As noted in the Evaluation Handbook, in order to ensure the reliability of the data collected, important issues related to bias and reliability had to be addressed. Reliability refers to producing the same result with repeated measurements.⁹ A major concern is that during interviews threats to reliability may be introduced. For example, interviewees may have underlying pre-existing opinions and perceptions based on privately held beliefs or may hold prevailing false or incomplete information on the topics discussed. In addition, the evaluators may have inadvertently introduced bias into interviews by asking leading questions, or recording data selectively based on their personally held preconceptions.

To address these threats to reliability of the data collected, interviewees were selected to represent a diverse range of institutional viewpoints on key topics under review. For example, for respondents

⁹ Handbook: How to Design and Conduct a Country Programme Evaluation at UNFPA (UNFPA Independent Evaluation Office, 2013, pp. 66-67)

responding to questions on relevance, evaluators posed questions to a diverse range of stakeholders, not just from one institution.

1.3.3. Application of Equity-focused and gender-responsive lens evaluation

This evaluation focused attention to selecting balanced samples of women and men, to the extent that this reflected the stakeholder, trainee and clients gender composition. The evaluation reached older persons and youth to some extent, as vulnerable and marginalized groups. The Tables 2 and 3 above provide gender-disaggregated information on stakeholders and trainees interviewed. The Table 3 provides gender-disaggregated information on clients consulted through FGDs, as well as broad categorization into two groups - older persons and youth.

1.4. Process overview

As outlined in the CPE evaluation handbook and the Cluster Evaluation TOR, the evaluation process was divided in four phases:

Phase 1: Desk review – The evaluation team has collaborated with the CO to identify and collect a wide range of relevant documents and data (primary and/or secondary) required for this evaluation. These materials have been placed in a password-protected cloud-based Google drive for ready access by the evaluation team.

Stakeholder mapping - Based on the list of stakeholders provided by the UNFPA CO, the evaluation team developed a sampling framework to select the pertinent implementing agencies, stakeholders and client/beneficiaries associated with outcomes, outputs and activities. The list of persons/institutions met is in Annex 2.

Phase 2: Data collection phase (in country) and drafting of CPE Report - Data were collected through interviews with selected stakeholders, trainees and clients. The main components of data collection were an in-briefing with the UNFPA and the ERG, stakeholder interviews, training follow-up interviews, client/beneficiary interviews and a FGD, followed by data synthesis. The main output for Phase 2 is a first draft of the CPE Report, presentation of preliminary findings, conclusions and recommendations at an out-briefing for UNFPA.

Phase 3: Synthesis of comments and drafting of second draft the CPE Report: The first draft report has undergone a quality assurance review by UNFPA followed by a formal review by the ERG. Following receipt of ERG comments, third draft of CPE Report was produced. The final version of CPE report will be produced after a dissemination workshop with all stakeholders, and comments received. The team leader is responsible to address all comments before finalizing the report.

Phase 4: The final phase includes the development of a management response to the evaluation recommendations, dissemination of the report and follow-up.

1.5. Team composition and distribution of tasks

As outlined in the Cluster Evaluation TOR, in addition to the international consultant Evaluation Team Leader, the CPE team consisted of two more persons: a National Evaluator, and a National Research Assistant. Initially envisaged National Experts in relevant fields of work could not be recruited due to the small niche in which activities are implemented, and active engagement of all local experts in implementation of past programmes. As a result, the CPE needed to be conducted without extended support.

CHAPTER 2: Country context

2.1. Development challenges and national strategies

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

BiH has been a potential candidate for European Union (EU) membership since 2008, when the Stabilization and Association Agreement between the European Communities and BiH was signed. This Agreement entered into force seven years later, in 2015, and in 2016, BiH formally applied for EU membership. The European Commission’s (EC) opinion regarding BiH’s candidacy is pending, given a required review of BiH’s answers to the EC’s Questionnaire. Relevant authorities in BiH have completed their answers in relation to Chapter 28 of *acquis communautaire* (Consumer protection and Health), among other Chapters.

Bosnia and Herzegovina (BiH) is an upper-middle income country. The country has a legacy of Yugoslav-era policies, simultaneously undergoing the late stages of transition from a planned to a decentralised economy, changes imposed by globalisation, and adaptations related to planned accession to the EU. As shown below in Figure 1, following a stable pre-global crisis expansion at about 5% annually, BiH’s economy suffered instability between 2008 and 2012, with low and negative growth rates. The recovery has been slow; annual growth rates have been positive since but lower than in the pre-crisis years.¹¹

BiH’s position on the global *Doing Business* index deteriorated in the last two years, following an improvement between 2014 and 2016 (Figure 2). It is now ranked 86th out of 190 economies, lagging significantly behind other countries/territory of South-eastern Europe.¹² Gross fixed capital formation (GFCF) has been on a downward trajectory since the 1990s and reached at least a ten-year low of 16.75% in 2017. For comparison, GFCF accounted for 27.1% of GDP in 2005.¹³

A high rate of government spending contributes to crowding out private investment and undermines private sector development. Whereas upper-middle income countries expend on average about 15% of GDP on government consumption, the rate for Bosnia and Herzegovina has generally floated between 21 and 23% over the last decade across the country, and only fell below 20% in 2017.¹⁴

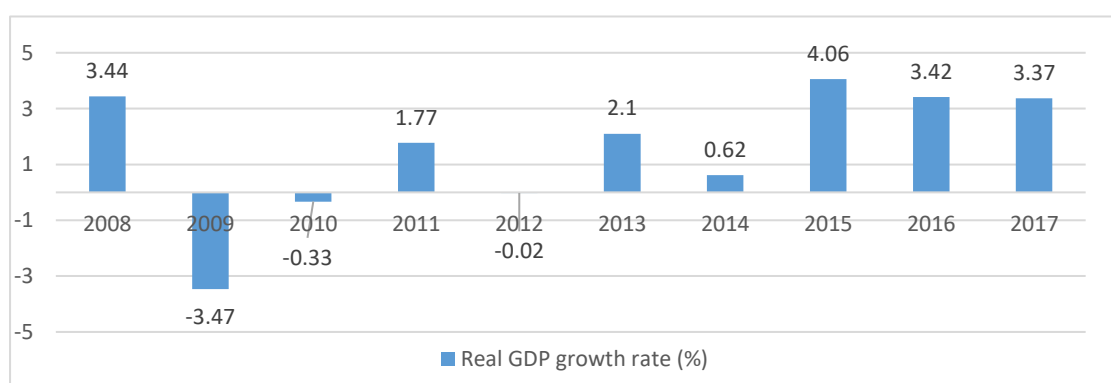


Figure 1 Real GDP growth rate (%), 2008-2017

¹⁰ 2018 Fragile States Index (The Fund for Peace, 2018)

¹¹ First Release. Gross Domestic Product by Expenditure Approach 2007-2017 (Agency for Statistics of Bosnia and Herzegovina, 2018d)

¹² Doing Business 2018: Reforming to Create Jobs (International Bank for Reconstruction and Development/ The World Bank, 2018)

¹³ (The World Bank Group, 2018a), Gross fixed capital formation (% of GDP)

¹⁴ General government final consumption expenditure (% of GDP) (The World Bank Group, 2018b)

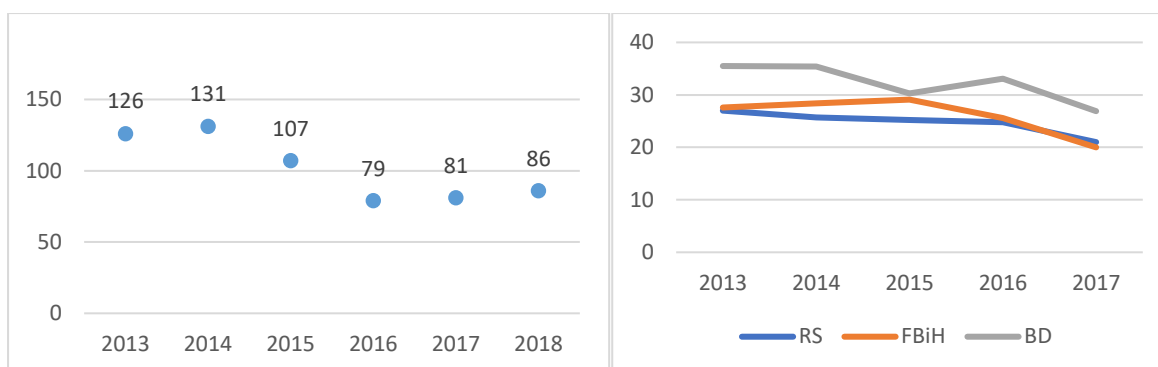


Figure 2 BiH standing on Doing Business, 2013-2018

Figure 2 Unemployment rates in BiH by entities and district, 2013-2017

The unemployment rate has ranged from 25 to 33% of labour force over the past couple of years, with higher unemployment rates in FBiH and the Brcko District. Those aged 15-24 and women face twice the odds of being unemployed compared to total workforce. The latest Labour Force Survey (2017) shows an apparent break from the trend, with a drop of five percentage points in the overall rate of unemployment (and apparent levelling between FBiH and RS) and almost 10 percentage points among youth (See Figure 3 above). Nevertheless, a careful examination of figures reveals that this sudden improvement owes less to an increase in employment than to a contraction of the labour force, which, in turn, is a result of an aging population and outward migration.¹⁵ While reliable numbers for emigration are not available, the Labour Force Survey (LFS) indicates that between 2013 and 2017, BiH has lost an estimated 252,000 people aged 15-64 – a decrease of 12% over a period of only four years, whereas the 65 and over population grew by 61,000 people.¹⁶

According to the latest Household Budget Survey (2015), there are 170,619 households in Bosnia and Herzegovina living in poverty, with 104,666 in FBiH, 62,501 in RS, and the remaining 3,452 in Brcko District. A total of 16.9% of the population lives below the national poverty line.¹⁷ This rate is lower in RS at 16.4%, whereas it stands at 17.1% in FBiH and 17.6% in Brcko District. The overall rate of poverty has dropped progressively since 2007, when it was at 18.2%. Unemployment is a significant, but not the sole determinant of risk of poverty and exclusion. The rate of poverty is much higher in households where the head of household is over 65 years old (20.8%), lacking any education (29.7%), unemployed (26.2%), or unable to work – a category composed in large part of people with disabilities and health problems – (38.5%).

	Life expectancy at birth	Expected years of schooling	Mean years of schooling	GNI per capita (2011 PPP\$)	HDI value
1990	70.9			1,562	
1995	71.6			2,024	
2000	74.4	11.6	7	7,440	0.672
2005	75.2	12.7	7.4	8,648	0.7
2010	75.9	13.4	7.1	9,879	0.713
2015	76.7	14.2	9	11,004	0.755
2016	76.9	14.2	9.7	11,353	0.766
2017	77.1	14.2	9.7	11,716	0.768

Table 5. BiH Human Development Index trends based on consistent time series data and new goalposts¹⁸

¹⁵ Labour Force Survey 2017 (Agency for Statistics of Bosnia and Herzegovina, 2017b)

¹⁶ Labour Force Survey 2015 (Agency for Statistics of Bosnia and Herzegovina, 2015)

¹⁷ Household Budget Survey 2015 (Agency for Statistics of Bosnia and Herzegovina, 2018e)

¹⁸ Briefing note for countries on the 2018 Statistical Update: Bosnia and Herzegovina (United Nations Development Programme, 2018)

Reproductive Health

In 2015, total health expenditure in BiH was 1,365,045,168 Euros or 9.4% of the GDP, with 70.9% of this amount spent on the public health sector and 29.1% on the private health sector. In RS in 2015, the total health expenditure amounted to 1,039,533,000 Euros or 11.4% of the GDP, with 72.8% of this amount spent on the public health care sector and 27.2% on the private health care sector. In FBiH in 2015, total health expenditure was 815,924,113 Euros or 8.5% of the GDP, with 70% of this amount spent on the public health sector and 30% on the private health sector. In the Brcko District in 2015, the total health expenditure was close to 34,487,482 Euros or 9.25% of the GDP, with 75% spent on the public health care sector and 25% spent on the private health care sector. The percentage of 1.6% of the total health expenditure in BiH was spent on prevention of diseases and conditions and health promotion, 2.3% in RS, 1.2% in FBiH and 0.9% in the Brcko District.¹⁹

Entities and the district in BiH have passed and implemented core and specialized legislation on health care and developed policies of specific health issues. The FBiH Government adopted the Strategy for Improvement of Sexual and Reproductive Health and Rights in 2010 for the period 2010-2019.²⁰ In RS, the Policy for Improvement of Sexual and Reproductive Health in RS was adopted for the period 2012-2017, and a new policy document is currently being drafted.²¹ The existing strategic policy documents focus on maternal health and protection, family planning and reduction of abortions, prevention of sexually transmitted diseases (STDs) and malignant diseases of the reproductive organs, as well as sexuality education and awareness.

Data on sexual and reproductive health in BiH is limited. Public health institutes are tasked with collecting data and producing statistical reports, but the data is not considered fully reliable as a result of a combination of factors, not least the issues with detection and reporting of diseases and interventions, and consistency of reporting by individual data sources. The last MICS²² was conducted for the period 2011-2012 and pertinent key findings for sexual and reproductive health are presented above in the introductory table. HIV prevalence is considered to be low, less than 0.1%.²³ The existing system of monitoring of sexual and reproductive health, which has specific limitations mentioned above, and which is not systemically complemented with alternative data sources, does not yield conclusive findings on the state of sexual and reproductive health.

Population and Development

In line with the 2013 Census report,²⁴ the total number of citizens in BiH is 3,531,159, out of which 1,798,889 are women, and 1,732,270 are men. According to this Census report, the number of population in FBiH is 2,210,220, in RS 1,228,423, and in BD 83,516. According to the RS Census Report, the population of RS is 1,170,342 (571,812 men and 598,812 women).²⁵ Other relevant population data is given in the Key Facts table above. It should be noted that the total population numbers in this table do not sum up to common figures from the different sources of statistics.

The fertility rate, at 1.26, remains one of the lowest in the world. The UN estimates BiH will have 40.5% of persons over 60 years of age by mid-century.²⁶ Population migrations to developed countries

¹⁹ Chapter 28: Consumer and Health Protection (Directorate for European Integration, 2018)

²⁰ Strategija za unapređenje seksualnog i reproduktivnog zdravlja i prava u Federaciji Bosne i Hercegovine 2010-2019 godina (Federalno ministarstvo zdravstva, 2010)

²¹ Politika za unapređenje seksualnog i reproduktivnog zdravlja u Republici Srpskoj (2012.-2017. godine) (Ministry of Health and Social Welfare of the Republic of Srpska, 2012)

²² Bosnia and Herzegovina Multiple Indicator Cluster Survey (MICS) 2011-2012 (Agency for Statistics of Bosnia and Herzegovina; Federal Ministry of Health; Ministry of Health and Social Welfare of Republika Srpska; Institute of Public Health FB&H; UNICEF, 2013)

²³ Strategija za odgovor na HIV i AIDS u Bosni i Hercegovini 2011-2016 (Council of Ministers of Bosnia and Herzegovina, 2011)

²⁴ The 2013 Census Report, although officially recognized by the BiH Agency for Statistics and the FBiH Institute for Statistics, as well as by the members of the International Monitoring Missions (including Eurostat, UNFPA, UNSD and UNECE), has been disputed by the RS Institute for Statistics for the reason of disagreement over the methodology used for data processing. Instead, the RS Institute for Statistics has developed own Census report that is in use in this entity. There has been no agreement between government institutions on how this issue will be solved so different administrations are using different census results.

²⁵ Rezultati popisa: gradovi, opštine, naseljena mjesta (Republika Srpska Institute of Statistics, 2017a)

²⁶ World Population Ageing, Report (United Nations, 2015b, str. 142)

are also underway, where mostly young, skilled people dissatisfied with the current socio-political situation leave Bosnia and Herzegovina, causing a major brain-drain. However, there are no comprehensive official data on migration. The BiH Security Ministry's Migration Profile for 2017 admits not being able to record and report comprehensive emigration figures, but reports a considerable number of people who took up jobs in EU countries in 2017 in comparison with 2016.²⁷

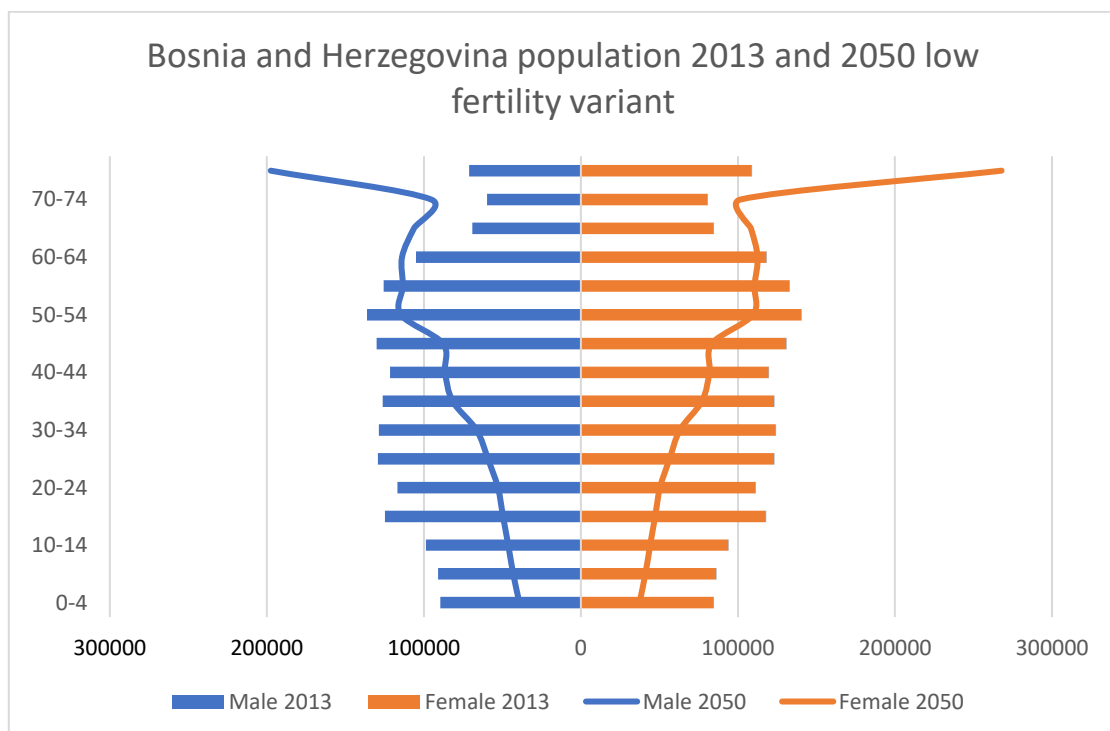
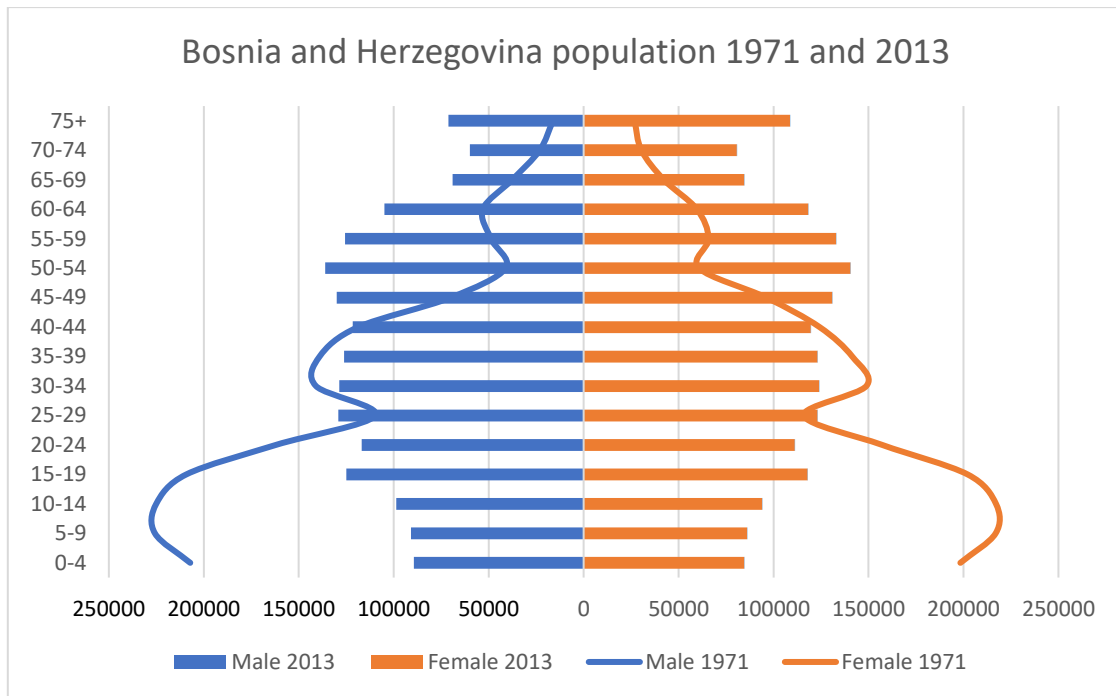


Figure 4 Population by age group and sex

²⁷ Bosnia and Herzegovina Migration Profile for the year 2017 (Ministry of Security of Bosnia and Herzegovina. Sector for Immigration, 2018)

While reliable numbers for emigration are not available, the Labour Force Survey indicates that between 2013 and 2017, BiH has lost an estimated 252,000 (180,000 from FBiH and around 73,000 from RS) people aged 15-64, whereas the 65 and over population grew by 61,000 people (39,000 in FBiH, 21,000 in RS and around 2,000 in Brcko District).²⁸ These shifts in the number and structure of population, and the migration trends, are a challenge to the country's development.

BiH does not avail itself of up-to-date development strategies at BiH or other levels of government, and with elaborated demographic aspects. State-wide strategies have not been adopted readily in general, which also includes youth issues. Government of Republika Srpska has recently announced an initiative for a National Demographic Recovery Programme of Republika Srpska.²⁹

Gender Equality

BiH has gender equality policies in place and is a signatory of the major international conventions and policy documents on the rights of women. The country has Gender Institutional Mechanisms at the BiH level, in FBiH and RS, and these institutions are in charge of implementing gender equality policies, monitoring the state of gender equality and proposing measures for improvement. BiH has been ranked 37 out of 160 countries in the 2017 in the Gender Inequality Index.³⁰ Despite the comprehensive legal and institutional framework for gender equality, the implementation of gender equality policies remains a challenge.

Political participation of women in BiH remains low despite the fact that a gender quota of 40% on the election lists has been stipulated by the Election Law (adopted in 2001, and amended a number of time through 2016). At the 2014 General Election, the representation of women among elected officials was 19.9%,³¹ which represented an increase from 17.37% in 2010 and 17.21% in 2006.³² After the 2018 General Elections, participation of women is at 21.42%.³³ In the executive branch of government (Council of Ministers at the BiH level, FBiH Government, and RS Government) women are rarely appointed to positions. In the term 2014-2018, of the total of 153 ministers in the country, only 23 were women (14.8%).³⁴ One exception was the RS Prime Minister's position and currently the RS President's position, held by a woman. Also, currently one vice president of the RS Government is a woman, as well as one vice president of FBiH. At the Local Election in 2016, 4% of all elected mayors were women, five in RS and one in FBiH.

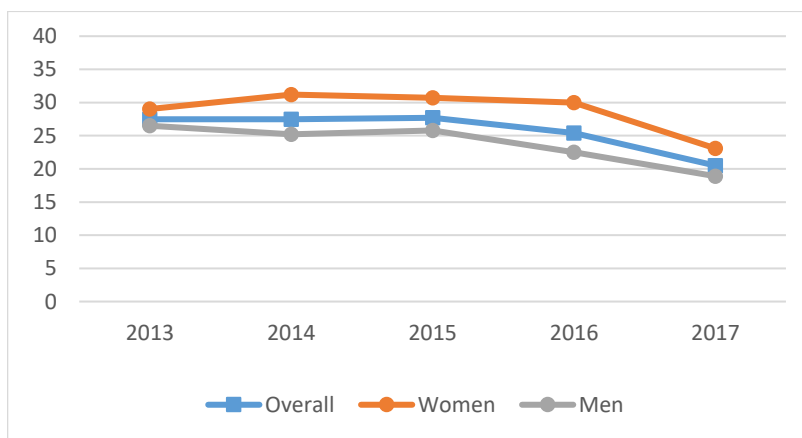


Figure 5 Unemployment rate, LFS 2013-2017.

While the overall rate of unemployment in the country was at around 25% for the past five years, the differences between women and men are noticeable – and even more pronounced in the rate of economic activity. The activity rate for women has consistently remained around only 32%, a full 10 percentage points below that for men, and women constitute 61.6% of discouraged persons in the labour

²⁸ (Agency for Statistics of Bosnia and Herzegovina, 2015), (Agency for Statistics of Bosnia and Herzegovina, 2017b)

²⁹ *Srpska dobija nacionalni program demografske obnove* (ATV, 2018)

³⁰ (United Nations Development Programme, 2018, p. 5), *Briefing note for countries on the 2018 Statistical Update: Bosnia and Herzegovina*

³¹ World Bank says 21.4% *Gender Data Portal: Bosnia and Herzegovina* (The World Bank, 2018c)

³² *Politička participacija žena u Bosni i Hercegovini: Analiza učešća žena na stranačkim listama i konačnih rezultata općih izbora 2014.* (Miftari, 2015)

³³ Ibid

³⁴ *Isaković: Od 153 ministara, svega 23 su žene* (SRNA, 2015)

market. Thus, although women make up 51% of working age population, they represent only 37.6% of employed persons.

There is a relatively comprehensive legal framework for combating **gender-based violence in BiH**, but the implementation has depended on availability of referral mechanisms, safehouses and other protection mechanisms across the country. The Study of Prevalence of Violence Against Women in Bosnia and Herzegovina³⁵ from 2013 found that as many as 47% of women have been subjected to some kind of violence at some point after the age of 15 (physical, psychological, sexual or economic violence). Findings of the Study indicate that the most frequent form of violence is psychological, followed by physical and sexual. The biggest share of reported violence (71.5%) is partner violence. During the conflict in BiH, sexual violence was used for the purpose of terrorizing and displacement of populations. The actual number of persons who were victims of sexual violence during the conflict in BiH cannot be established with certainty.

Youth

Youth policies have only been adopted in Republika Srpska, but not in FBiH, or at BiH level. According to the 2013 Census, 28.7% of the BiH population was under the age of 25 and 15.4% was younger than 15. During the last 15 years prior to the census, the size of almost every consecutive cohort decreased by around 900 babies on average. This steady decline in the young population is coupled with migratory trends. The unemployment rate for those aged 15-24 is approximately twice the overall rate.

Children are disproportionately affected by poverty, as households with more children face higher odds of falling below poverty line.³⁶ As a result of multiple vulnerabilities, the number of minors registered as beneficiaries of social welfare remains high (133,000 as of 2016) even after the stabilisation following economic recovery since 2012.

Adolescent birth rate has steadily declined since 2000, when it was 21.4 births per 1,000 women.³⁷ According to the latest available data, the adolescent birth rate in Bosnia and Herzegovina was 11³⁸ per 1,000 women (9.5³⁹ in RS and 11.4⁴⁰ in FBiH). Overall, according to the latest data for 2016, 4.3% of live births in Bosnia and Herzegovina are by mothers aged 15-19⁴¹ (3.5%⁴² in RS for 2016 and 4.5%⁴³ in FBiH for 2016). In 2016, marriages in which one or both of the partners were 15-19 years old accounted for 10.5% of all marriages⁴⁴ (approximately 12.7%⁴⁵ in FBiH and 7.9%⁴⁶ in RS).

2.2. The role of external assistance

As shown below in Table 6, the overall disbursements for BiH have declined since 2008 and 2009 when they were at their highest levels, at \$285 million for BiH, to a more constant lower level in 2016, at \$164 million.⁴⁷

³⁵ *Prevalence and Characteristics of Violence against Women in BiH* (Babović, Pavlović, Ginić, & Karađinović, Prevalence and characteristics of violence against women in BiH, 2013)

³⁶ *Household Budget Survey 2015* (Agency for Statistics of Bosnia and Herzegovina, 2018e)

³⁷ *Sustainable Development Goals (SDGs)* (The World Bank Group, 2018d)

³⁸ *Demography 2016* (Agency for Statistics of Bosnia and Herzegovina, 2017d)

³⁹ Calculated based on data on live births, still births, and population estimates in 2017 from *Demographic Statistics* (Republika Srpska Institute of Statistics, 2018a). Verified by the Ministry of Health and Social Welfare of Republika Srpska.

⁴⁰ *Statistical Yearbook* (Institute for Statistics of FBiH, 2017a)

⁴¹ *Demography 2016* (Agency for Statistics of Bosnia and Herzegovina, 2017d)

⁴² *Statistical Yearbook of Republika Srpska 2018* (Republika Srpska Institute of Statistics, 2018b)

⁴³ *Statistical Yearbook 2018* (Institute for Statistics of FBiH, 2018c)

⁴⁴ *Demography 2016* (Agency for Statistics of Bosnia and Herzegovina, 2017d)

⁴⁵ *Statistical Yearbook* (Institute for Statistics of FBiH, 2017a). The rate is approximated as the Institute for Statistics of FBiH did not publish the joint distribution of marriages by bride/groom age group; thus, the marriages where both the bride and the groom are in the 15-19 age group are counted twice, so the number reported here is potentially an over-estimate.

⁴⁶ *Statistical Yearbook* (Republika Srpska Institute of Statistics, 2017b)

⁴⁷ Official Development Assistance Disbursements (ODA) include all types of aid (e.g. grant, loan, technical co-operation) on a disbursement basis (i.e. actual expenditures). The data cover flows from all bilateral and multilateral donors.

Table 7 shows total annual UNFPA contributions to the four programmes from 2008 through 2017 (This is excluding funds from other sources for UNFPA related activities). Overall, for the past ten years, UNFPA commitment has ranged between \$0.37 to \$0.58 million on annual basis.

*Table 6 Total Official Development Assistance disbursements to four programmes 2008 to 2016.*⁴⁸

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

*Table 7 Total UNFPA contributions to four programmes from 2008 through 2017 (excludes funds from other sources for UNFPA activities).*⁴⁹

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

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

Tables 8 and 9 below demonstrate other external assistance (by UN agencies) in UNFPA focus areas.

*Table 8 Overview of UN agencies' contributions to focus areas also addressed by UNFPA (dollar amounts)*⁵⁰

	CSO advocacy for CEDAW, Istanbul Convention	Increased national capacity to deliver SRHR	Integrated systems of social protection	Local DRR	Quality and inclusive education	Regulatory and institutional frameworks for DRR	Social protection and population policies	Strategies to prevent and respond to VAWG	Grand Total
IOM			1,150,000	2,690,000		1,300,000		451,600	5,591,600
UN Women	965,000					0		1,111,000	2,076,000
UNDP			3,405,000	31,026,307		4,050,000	200,000	454,000	39,135,307
UNESCO				2,864,000		230,000			3,094,000
UNFPA	235,000	508,600	0	130,000	140,000	0	115,000	405,000	1,533,600
UNHCR			18,271,035				30,000	708,429	19,009,464
UNICEF			1,960,000		2,843,000		554,400	1,324,000	6,681,400
UNODC					298,000				298,000
UNV	56,000	20,500	45,610		117,220			41,000	280,330
Grand Total	1,256,000	529,100	24,831,645	36,710,307	3,398,220	5,580,000	899,400	4,495,029	77,699,701

⁴⁸ Source: Dataset: Aid (ODA) disbursements to countries and regions [DAC2a] Definition: Destination of Official Development Assistance Disbursements (ODA Disbursements). Geographical breakdown by donor, recipient and for some types of aid (e.g. grant, loan, technical co-operation) on a disbursement basis (i.e. actual expenditures). The data cover flows from all bilateral and multilateral donors except for Tables DAC 1, DAC 4, DAC 5 and DAC 7b which focus on flows from DAC member countries and the EU Institutions. stats.oecd.org

⁴⁹ Source: Dataset: Aid (ODA) disbursements to countries and regions [DAC2a]. stats.oecd.org

⁵⁰ Source: One UN Programme BiH Joint Work Plans 2015-2016 and 2017-2018, Pillars 1, 3, 4.

Table 9 Overview of UN agencies' contributions to focus areas also addressed by UNFPA (percentage)⁵¹

	CSO advocacy for CEDAW, Istanbul Convention	Increased national capacity to deliver SRHR	Integrated systems of social protection	Local DRR	Quality and inclusive education	Regulatory and institutional frameworks for DRR	Social protection and population policies	Strategies to prevent and respond to VAWG	Grand Total
IOM	0.0%	0.0%	4.6%	7.3%	0.0%	23.3%	0.0%	10.0%	7.2%
UN Women	76.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	24.7%	2.7%
UNDP	0.0%	0.0%	13.7%	84.5%	0.0%	72.6%	22.2%	10.1%	50.4%
UNESCO	0.0%	0.0%	0.0%	7.8%	0.0%	4.1%	0.0%	0.0%	4.0%
UNFPA	18.7%	96.1%	0.0%	0.4%	4.1%	0.0%	12.8%	9.0%	2.0%
UNHCR	0.0%	0.0%	73.6%	0.0%	0.0%	0.0%	3.3%	15.8%	24.5%
UNICEF	0.0%	0.0%	7.9%	0.0%	83.7%	0.0%	61.6%	29.5%	8.6%
UNODC	0.0%	0.0%	0.0%	0.0%	8.8%	0.0%	0.0%	0.0%	0.4%
UNV	4.5%	3.9%	0.2%	0.0%	3.4%	0.0%	0.0%	0.9%	0.4%
Grand Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

⁵¹ Calculations based on data from One UN Programme BiH Joint Work Plans 2015-2016 and 2017-2018, Pillars 1, 3, 4.

CHAPTER 3: UN/UNFPA response and programme strategies

3.1. UN Strategic response

Two documents, which span over the period 2010 to 2020, are relevant for the evaluation period (2013-2018). The BiH Council of Ministers and the United Nations Country team (UNCT) formulated and signed the first United Nations Development Assistance Framework (UNDAF) document for the period 2010-2014 in March 2009. The second UNDAF was signed in June 2015 for the period 2015-2019. In BiH, this UNDAF was extended in 2018 through 2020.

The focus areas/outcomes outlined in the two UNDAF documents have changed within the two UNDAF timeframes depending on identified priorities. The focus in UNDAF 2010-2014 was on democratic governance, social inclusion, and human security. In the 2015-2019 (2020) UNDAF, the focus on social inclusion and human security (in addition to rule of law) is maintained, and the focus area of empowerment of women is added. It is important to note that, apart from common outcomes, the first UNDAF also identifies outputs specific to individual UN agencies in BiH, while this is replaced with targets and indicators in the second UNDAF, without clearly assigned roles of individual UN agencies.⁵²

UNFPA has been assigned to contribute to the delivery of the following focus areas/outcomes individually or in cooperation with other UN agencies in the periods 2010-2014 and 2015-2019 (2020). Please see Annex 9 for the selection of focus areas/outcomes to which UNFPA was assigned to contribute. Specific activities from UNFPA CPD and AWP have been integrated into UNDAF implementation documents.⁵³

3.2. UNFPA strategic response

UNFPA's global strategic goal, as identified in the Strategic Plans 2014-2017 and 2018-2021 has remained the same: to "achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the agenda of the Programme of Action of the International Conference on Population and Development, to improve the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality".

An overview of UNFPA Strategic Plans, with outcomes and outputs is in the Annex 8. A summary of the theory of change under the current UNFPA Strategic Plan 2018-2021 can be found in Annex 10 .

The most recent UNFPA Strategic Plan, for 2018-2021, has incorporated the Sustainable Development Goals (SDGs) into its framework. By adopting the Sustainable Development Goal indicators in the UNFPA integrated results and resources framework, the outcomes of the UNFPA strategic plan for 2018-2021 reflect the results shared with other partner organizations. The 2030 Agenda for the SDGs provides scope for UNFPA to continue to implement the Programme of Action of the International Conference on Population and Development (ICPD). The UNFPA Strategic Plan is aligned with specific SDGs, most notably, to Goal 3 (Ensure healthy lives and promote well-being for all at all ages); Goal 5 (Achieve gender equality and empower all women and girls); Goal 10 (Reduce inequality within and among countries); and Goal 17 (Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development).

The most relevant targets for UNFPA CP in BiH, which could be considered both in assessing the current programme achievements and in future programming, are outlined in Annex 11.

Sixty per cent of the outcome and impact indicators in the UNFPA Strategic Plan 2018-2021 are SDG indicators. All of the SDG indicators prioritized by UNFPA are captured in the integrated results and

⁵² When reviewing the UNDAF document, it should be taken into consideration that Joint Work Plans are annexes to UNDAF, they are developed on bi-annual basis and they have clearly assigned contributions of individual agencies to outcomes and outputs.

⁵³ See One UN Programme Bosnia and Herzegovina Joint Work Plans 2015-2016 (United Nations. Office of the Resident Coordinator, Bosnia and Herzegovina, 2014a), (United Nations. Office of the Resident Coordinator, Bosnia and Herzegovina, 2014b), (United Nations. Office of the Resident Coordinator, Bosnia and Herzegovina, 2014c), and 2017-2018 (United Nations. Office of the Resident Coordinator, Bosnia and Herzegovina, 2016a), (United Nations. Office of the Resident Coordinator, Bosnia and Herzegovina, 2016b), (United Nations. Office of the Resident Coordinator, Bosnia and Herzegovina, 2016c)

resources framework (Annex 1 in UNFPA Strategic Plan 2018-2021) at the levels of goals and outcomes.

3.3. UNFPA response through country programmes

UNFPA support to BiH began in 1995. Until 2004, UNFPA operated on a project basis. Past UNFPA assistance concentrated on improving the reproductive health status of women and adolescents and on improving access to, and the quality of, reproductive health and health education. In 2004, in accordance with United Nations reform, UNFPA participated in joint programming as part of the first UNDAF.⁵⁴ The first formal Country Programme Document (CPD) was approved by the Executive Board of the United Nations Development Programme and of the United Nations Population Fund at the May-June 2009 session for the period 2010-2014 (DP/FPA/DCP/BIH/1). The second UNFPA CPD for BiH (DP/FPA/CPD/BIH/2) was approved in September 2014. The programme initially covered the period from 2015 to 2019, but has been extended for one year through 2020.⁵⁵ An overview of CPDs, including pertinent outcomes, outputs and targets is given in Annex 12.

The period under review by this evaluation is 2013-2018, which spans over not only two UNFPA country programmes in BiH, but also three UNFPA strategic plans at the global level (2008-2013, 2014-2017, 2018-2021), and two UNDAF documents (2010-2014, 2015-2019/20). **It should be noted that this evaluation is carried out on parts of two CPDs and that two years are remaining for implementation of CPD 2015-2019/2020. This means that the assessment of effectiveness of programme areas below represents stock taking at the end of 2018 without prejudging the results of further implementation until the end of 2020.** As stated in CPDs, the CPs have been aligned with the UNDAF, UNFPA Strategic Plans, recommendations of the Common Country Assessment from 2013, and a pertinent CPE for BiH from 2013, as well as national priorities, including: (a) the priorities of the Bosnia and Herzegovina Coordination Board for Economic Development and European Union Integration; (b) “the national development and social inclusion strategies” (as stated in CPD 2010-2014); and (c) the country's aspiration toward joining the EU. The UNFPA CPs were based on the basic principles of human rights and gender equality, and on the goals of the ICPD Programme of Action.⁵⁶

The areas of intervention of UNFPA BiH in the evaluation period have been the following:

Table 10 UNFPA budget areas of intervention for 2010-2014 and 2015-2019 (2020)

2010-2014	Planned budget, in millions USD	2015-2019 (2020)	Planned budget, in millions USD
Reproductive health and rights	3.7	Sexual and reproductive health	1.0
Population and development	1.9	Population dynamics	0.5
Gender equality	1.0	Gender equality and women's empowerment	0.7
		Adolescents and youth	0.9
Programme coordination and assistance	0.3	Programme coordination and assistance	0.3
Total	6.9		3.4

BiH is a pink country in terms of UNFPA global categorization of business models. This means that the allowed modes of intervention for UNFPA in BiH are advocacy and policy dialogue/advice,

⁵⁴ *Draft country programme document for Bosnia and Herzegovina* (Executive Board of the United Nations Development Plan and of the United Nations Population Fund, 2009)

⁵⁵ *Terms of Reference for the Evaluation of the Programme for Bosnia and Herzegovina, The Republic of North Macedonia, the Republic of Serbia and Kosovo* (United Nations Population Fund, 2018)

⁵⁶ *Draft country programme document for Bosnia and Herzegovina* (Executive Board of the United Nations Development Plan and of the United Nations Population Fund, 2009), *Country programme document for Bosnia and Herzegovina* (Executive Board of the United Nations Development Plan and of the United Nations Population Fund, 2014)

capacity development and knowledge management. As of 2018, UNFPA COs are allowed to provide services too, if funds come from non-core resources. The BiH Logic Model is shown in the Annex 7. An overview of CPDs and focus areas is given in Annex 12.

CHAPTER 4: Findings: answers to the evaluation questions

4.1. Sexual and reproductive health and rights

4.1.1. Relevance

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

Summary findings
Under this component, the UNFPA programme has been largely adapted to the needs of women and migrants. The programme has been largely in line with international policy frameworks, UNFPA strategic plans, and the UNDAF. The programme generally refers to domestic policies for SRHR as a result of consultation with domestic health authorities. UNFPA successfully responded in two situations of aggravated humanitarian crisis – during the 2014 floods and the 2018 migrant crisis, by delivering activities related to affected population health and GBV.

There is evidence that the UNFPA programme has been adapted to some extent to different needs of different groups of population, most notably women, but not of marginalized and vulnerable populations. The Country Programme Documents (CPDs) 2010-2014 and 2015-2019(2020) define the outcomes related to Sexual and Reproductive Health and Rights (SRHR) with varying focus on specific target groups. The CPD 2010-2014 focuses on health, health education and family planning policies and services that are inclusive of the elderly, women, youth, and people at risk of HIV infections, as well as socially excluded sub-groups of some of these populations (youth and women). The CPD 2015-2019(2020) places additional focus on increased availability and use of integrated sexual and reproductive health services for Roma, among other vulnerable populations.⁵⁷ This CPD quotes a recommendation from 2013 CP Evaluation⁵⁸ that the focus on marginalized groups should increase.

The CPD 2015-2019(2020) claims applying a human rights-based approach in all interventions, including reliance on the principle of access to affordable, integrated sexual and reproductive services that are high-quality and meet human rights standards, eliminating all forms of discrimination and empowering of marginal groups, with an emphasis on women, adolescents and youth (particularly girls). The CPDs do not make specific reference to gender mainstreaming, but women's rights feature highly in both documents in the area of SRHR as specific interventions are intended for inclusion of women in health and health education policies, relevant SRHR service provision, with focus on maternal health. Youth also feature highly as a target group in CPDs, while particular emphasis is placed on girls in the CPD 2015-2019(2020). However, men are not defined as a specific target group.

UNFPA CO commissioned several needs assessments in the area of SRHR.⁵⁹ However, apart from the evident focus on women in the report on breast and cervical cancer screening, the documents do not dedicate specific attention to other groups and sub-groups of population, including vulnerable and

⁵⁷ The selection of target groups is generally in line with findings of the *Common Country Assessment Bosnia and Herzegovina 2013* (United Nations Country Team, 2013), which identifies the following groups as the most vulnerable: persons with disabilities, returnees, displaced persons, Roma, families with two or more children, women, especially female heads of households, the elderly, the unemployed and low-skilled youth, particularly in rural and semi-urban areas.

⁵⁸ *UNFPA Country Programme Evaluation* (Clark, Golemac Powell, & Durmo, 2013; Clark, Golemac Powell, & Durmo, 2013)

⁵⁹ Including a report on *The Implementation of Breast and Cervical Cancer Screening Programs in Bosnia and Herzegovina* (Davies, Pilav, Siljak, & Beslija, 2013) and *Recommendations regarding Reproductive Health and Family Planning Training in Bosnia and Herzegovina* (Koo, Vuckovic, & Trifunovic, 2013)

marginalized categories. Information from the latest MICS (2011-2012)⁶⁰ and the MICS on Roma (2011-2012)⁶¹, which were published in 2013, was used as evidence in the CPD 2015-2019(2020), while the CPD 2010-2014 generally lacked a similar evidence base. The evidence base concerning maternal mortality, contraceptive prevalence rate, the unmet need for family planning, and women's health, which was collected from various sources for the purpose of this evaluation (see the introductory table on p. xi), proves the relevance of UNFPA interventions under the SRHR outcome. However, a comprehensive Demographic and Health Survey (DHS) has not been conducted, despite efforts of UNFPA CO's investment in development of DHS proposal together with statistical institutions in BiH. This considerably limited the availability of an up-to-date evidence base for programming interventions in line with needs of specific demographic groups. Stakeholders interviewed believe that the UNFPA programme is generally well adapted to the needs of specific target groups, particularly women. However, there are also a number of stakeholders who believe that persons with disabilities, youth, people at risk of HIV infection, and Roma have been largely neglected in this area of intervention. This was proven by analysis of Annual Work Plans (AWPs) and Country Office Annual reports (COARs), which generally do not indicate activities oriented toward specific target groups. It was stressed by some stakeholders that the UNFPA Country Programme (CP) intended to build systems and capacities of these systems to be able to respond to everyone's needs in the health sector.

UNFPA programme is mostly aligned with international and national policy frameworks and has been able to adapt to a changing local context. UNFPA CPDs for BiH reflect clearly the global UNFPA strategic goal and outcomes, translating them into individual outcomes and outputs related to SRHR at country level. The interventions planned in AWPs are in line with UNFPA's global framework, focusing on support to development of SRH policies, contraception advocacy and family planning repositioning, recommendations for breast and cervical cancer screening, production of guidelines to improve maternal health, maternal death surveillance, and integration of MISP into emergency response preparedness.⁶²

UNFPA CPDs do not quote the International Conference on Population and Development (ICPD) goals but they are reflected in the CP. In the area of SRHR, the interventions are clearly in line with the ICPD Programme of Action objectives related to sexual and reproductive health and reproductive rights (including in cases of emergencies), family planning, sexually transmitted diseases and prevention of HIV, women's health and safe motherhood.⁶³ Sustainable Development Goals (SDGs) were not adopted at the time of CPD drafting and approval, and the latest CPD has not changed as a result of SDGs adoption. However, some UNFPA interventions in SRHR are pertinent to SDGs (please see Table 9 Overview of SDGs and targets relevant for UNFPA CP).

UNFPA programme is aligned with priorities set in the UNDAF for the periods 2010-2014 and 2015-2019(2020) under the pillars of Social Inclusion and Human Security. The key targets from UNFPA's CPD 2015-2019(2020) and relevant AWPs have been integrated into the UNDAF (see overview of UNFPA's alignment with UNDAF under 4.5. UNCT Cooperation and Added Value).

When it comes to alignment with domestic policy frameworks, the CPD 2010-2014 made reference to the Social Inclusion Strategy (2008-2013), while the subsequent CPD referred to the 2012 national policy on sexual and reproductive health under the SRHR outcome. It should be noted that RS had adopted the SRH Policy in 2013 for the period 2012-2017⁶⁴ and FBiH had adopted its SRH Strategy in

⁶⁰ (Agency for Statistics of Bosnia and Herzegovina; Federal Ministry of Health; Ministry of Health and Social Welfare of Republika Srpska; Institute of Public Health FB&H; UNICEF, 2013)

⁶¹ *Multiple Indicator Cluster Survey (MICS) 2011-2012, Bosnia and Herzegovina: Roma Survey* (The Ministry for Human Rights and Refugees of Bosnia and Herzegovina and the Agency for Statistics of Bosnia and Herzegovina, 2013)

⁶² These interventions correlate to Outcome 1, Outputs 1, 2, 3 and 5 from the Strategic Plan 2014-2017 and Outcome 1, Outputs 1, 2 and 3 from the Strategic plan 2018-2021.

⁶³ *Programme of Action* (United Nations Population Fund, 2004)

⁶⁴ *Politika za unapređenje seksualnog i reproduktivnog zdravlja u Republici Srpskoj (2012.-2017.godine)* (Ministry of Health and Social Welfare of the Republic of Srpska, 2012)

2010 for the period 2010-2019.⁶⁵ Stakeholders from governmental authorities have confirmed that the UNFPA CO has always engaged in thorough consultation and planning processes with them in order to ensure that the proposed interventions matched domestic policies and priorities.⁶⁶

The biggest changes in the national development context occurred at times of specific crises, most notably during the 2014 floods and 2018 migrant crisis. According to stakeholders, as well as COARs, UNFPA has been able to respond to these changes by mobilizing resources to address the country's newly emerging needs. Although the CPDs do not specifically make reference to direct emergency response, integrating MISP in emergency plans and building of capacities for protecting women in emergencies have been foreseen as specific intervention of UNFPA CP. UNFPA is recognized among most stakeholders as an agency that responded appropriately and timely at the time of floods in BiH in 2014 and during the migrant crisis in 2018.

UNFPA has delivered some interventions to prevent and respond to STIs, including HIV/AIDS, for example by extending the Family Planning module for training of family medicine doctors to these topics, and integrating these issues into SRH strategies in entities. However, the fact that the Global Fund programme worth 60,230,469 USD has ended and its results should be taken into account for adjusting UNFPA interventions. Namely, although the reported HIV prevalence is low, there have been reports on an increased number of registered HIV-infections in 2018.⁶⁷

4.1.2. Effectiveness

Evaluation questions
EQ3. To what extent have the intended programme outputs been achieved? To what extent did the outputs contribute to the achievement of these planned outcomes: increased utilization of integrated SRH Services by those furthest behind, and what was the degree of achievement of the outcomes?
EQ 4 To what extent has UNFPA contributed to an improved emergency preparedness in BiH, and in the area of maternal health / sexual and reproductive health including MISP?
EQ5 To what extent has each office been able to respond to emergency situations in its Area of Responsibility (AoR), if one was declared? What was the quality and timeliness of the response?

Summary findings
UNFPA has partly met the targets set for interventions related to family planning repositioning and adoption of clinical guidelines. Although a number of pertinent activities have been delivered, the outputs related to maternal morbidity and mortality surveillance and integration of MISP into national preparedness plans have not yet been achieved, although initiated. UNFPA has contributed to creating key underlying assumptions for increased utilization of integrated SRH services, although not focusing on those furthest behind. UNFPA responded to 2014 floods and 2018 migrant crisis, largely in a timely and good quality manner.

Achievement of outputs

In order to assess the extent to which the intended programme outputs have been achieved over two programming cycles, a selection of comparable outputs has been made. These outputs are “Health ministries coordinate and develop intersectoral family planning and reproductive health commodity security policies and strategies to improve women’s health” from the CPD 2010-2014 and “Increased

⁶⁵ *Strategija za unapređenje seksualnog i reproduktivnog zdravlja i prava u Federaciji Bosne i Hercegovine 2010-2019 godina* (Federalno ministarstvo zdravstva, 2010)

⁶⁶ For example, official figures in BiH suggest that this country does not have maternal mortality issues that are comparable to some other countries, as quoted in UNFPA Strategic Plan 2014-2017 (“800 women still die every day from childbirth and the complications of pregnancy”). For this reason, the intervention Beyond the Numbers, which was initially envisaged by the UNFPA in BiH, was replaced, in consultation with domestic partners, by an intervention which is intended to pilot an obstetric surveillance system based on near-miss cases, in order to suit more the context of BiH.

⁶⁷ *KCUS tokom testiranja ove godine otkrio 20 novih slučajeva infekcije HIV virusom* (FENA, 2018)

national capacity at state and entities level to deliver integrated sexual and reproductive health services, with focus on Roma and vulnerable populations” from the CPD 2015-2019(2020).

The targets set for these outputs are the following: 1. Family [planning] policy action plan established at entity levels, 2. Number of guidelines, protocols and standards for healthcare workers developed for delivery of quality SRHR services (including adolescents and youth), 3. Percentage of service delivery points at primary health-care level providing at least three integrated sexual and reproductive health services, 4. Mechanism for maternal death surveillance and response system established at state and entities levels, 5. Elements of Minimum Initial Service Package for reproductive health in crisis situations integrated into state emergency preparedness plans. The achievement of these targets is elaborated below.

Family planning action plans not made; family planning counselling as part of integrated SRH services targets partly met (targets 1 and 3). UNFPA reported work on a needs assessment to develop strategic recommendations regarding activities in the area of FP/RH, including youth, gender-equality and provision of high-quality standardized FP services in 2013. Along with this activity, UNFPA worked on introduction of the concept of Total Market Approach (TMA) and brought together different national stakeholders to acquaint them with what the public sector, commercial suppliers, and nongovernmental organizations can do to ensure a reliable supply of reproductive health commodities, in particular for family planning and HIV prevention. This activity resulted in a TMA Action Plan. In 2015, capacities of family physicians and gynaecologists from primary health care were developed/strengthened to deliver training on family planning through the Family Planning training package and Training of Trainers. These doctors delivered trainings in 2016, 2017 and 2018 to participants from 28 communities, ending up training the total of 318 family physicians by the end of 2018. There have been a total of 22 trainings (including Training of Trainers), 9 in RS, one in BD and 12 in FBiH.

UNFPA reported that these physicians were now able to deliver human rights-based and patient centered family planning counselling and services. The stakeholders interviewed, as well as trainees, praised the trainings delivered to family physicians by teams of doctors.⁶⁸ Activities related to demand generation for family planning were reported as completed, with a caveat that the dissemination of messages could not be measured and that social marketing could not be done, which remained the case through 2017.

The relevant targets are related to adoption of family planning action plans and 25% of service delivery points at primary health-care level providing at least three integrated reproductive health services. It was not reported that action plans had been made or endorsed by relevant authorities. It could be argued that by delivery of training for family physicians and accompanying promotional activities, the target related to integrated SRHR services was partly met under the assumption that family doctors actually implement family planning counselling in their practices.

Planned number of clinical guidelines for maternal health partly achieved (target 2). Another intervention under this programme area was the development of clinical guidelines for maternal health. The preparatory work and planning for development of these guidelines started in 2014 and rolled out in subsequent years. Three sets of clinical guidelines (Postpartum Haemorrhage (PPH), Preeclampsia, and Guidelines for Development of Clinical Guidelines) have been developed by the working group appointed by the FBiH Ministry of Health, and one set of guidelines has been developed by the working group appointed by the RS Ministry of Health and Social Welfare, while another set is still being

⁶⁸ It was noted that the training consisted of four modules, adapted to local context from best international practices, and delivered by trainers who were trained to deliver substantive training to adult professionals. The substance consisted of topics related to legislation, ethics, logistics, contraception and counseling. Interviewed trainees have confirmed usefulness of training and quoted individual examples of how they used new, or refreshed knowledge in practice (e.g. contraception advice, contraindications for other medicines, role of contraception in addressing other reproductive health issues). Some, however, stated a number of obstacles to giving family planning advice, including high numbers of patients, particularly older persons, and confidentiality issues.

drafted, in cooperation with the Eastern European Institute for Reproductive Health. The methodology and guidelines themselves have been drafted in line with best international practices. The guidelines were endorsed by both the FBiH Ministry of Health and the RS Ministry of Health and Social Welfare and presented widely. Stakeholders interviewed commended this process and final results as a very big contribution to informing the practice of healthcare workers. They said that such clinical guidelines were very relevant for maternal health and very much needed by clinics. This was confirmed as a quality requirement for medical institutions by the accreditation agencies (Agency for Quality and Accreditation in the Health Sector in FBiH and Agency for Certification, Accreditation and Improvement of Health Care in RS), which endorsed the guidelines. PPH posters containing guides/algorithms have been displayed in 14 medical institutions in RS in critical/visible places in delivery rooms. The guides have been presented at a conference of Association of Gynaecologists in RS and gynaecologists in FBiH. According to stakeholders, the Preeclampsia guide should be disseminated even wider because other doctors are also involved in monitoring pregnancies. In terms of the target for this output, four guidelines, protocols and standards for healthcare workers for delivery of quality SRHR services are expected to be delivered as part of the 2015-2019(2020) CP. So far, three guides have been drafted, while the fourth is expected to be drafted in the course of 2019.

Mechanism for maternal death surveillance and response system not established (target 4).

According to COARs, UNFPA started activities on the initiative “Expanding Beyond The Numbers-Maternal Mortality and Morbidity Case Reviews” in 2014 by supporting participation of representatives from BiH in a regional workshop with a view of introducing the BtN tools and methodology to countries/territory in the Eastern European Region. The development of BtN methodology started in 2016. In 2017, a group of trainers were trained to use the methodology. In 2018, according to stakeholder interviews, the work on BtN continued with attempts to develop action plans for rollout and piloting the methodology in relevant medical institutions. Some stakeholders praised this initiative of UNFPA, saying that although BiH is a country with low maternal mortality, the surveillance should be extended to near miss cases during pregnancy and 42 days after delivery. In 2018, a new concept and methodology for establishing a National Obstetric and Response Surveillance System (OSRS) for Countries/territory in Western Balkans was developed, including a draft architecture and administrative arrangements for organizing the OSRS and the logical structure of the electronic reporting application. The OSRS is based on BtN methodology. Individual stakeholders stated that the BtN system was not adapted to the BiH context and that health institution managers were not necessarily open for this kind of surveillance. Individual stakeholders have questioned this target as a whole, stating that a system for monitoring maternal mortality already exists as part of relevant statistical and public health institutions’ records. It could, however, still be argued that the output indicator was not met as a mechanism for maternal death surveillance and research into causes maternal mortality and morbidity, as well as the response system, has not yet been established at the state and entity levels (as defined by this target), although initiated.

South-South cooperation does not feature in the CPD 2010-2014, but its promotion is planned in the CPD 2015-2019(2020). Evidence of utilization of this platform in the CP has been found in the area of SRHR. More specifically, stakeholders from BiH participated in two inter-country workshops (eight countries and territories) on maternal mortality and morbidity surveillance in line with WHO “Beyond the Numbers” methodology, first in cooperation with the Regional Development Center on Public Health Services in the former Yugoslav Republic of North Macedonia and then with the East European Institute for Reproductive Health in Romania ([https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_PUB_2018_EN_SSTC_in_Action_-_Sexual_Reproductive_Health.pdf, p. 31]).

MISP not integrated into emergency preparedness plans (target 5).

The intended target was integration of Minimum Initial Service Package (MISP) into national emergency preparedness plan. UNFPA has contributed to the country's emergency preparedness by delivering several interventions, largely under the SRHR component. MISP Training of Trainers (TOT) was organized for national participants already in 2013, and good practices and lessons learned were shared among countries/territory in the EECA region. In 2014, MISP training was conducted for key stakeholders at different levels in BiH. An assessment of national capacity to implement MISP has been conducted and an action plan has been developed, according to 2014 Annual Report. In 2017, the MISP Working Group completed the initial MISP readiness assessment for BiH, which shows elevated need for continuous support to health authorities in preparation for emergency situations. In 2017, the capacities of 45 institutional representatives (primary health care centres, civil protection, police, centres for social welfare, NGOs and municipal authorities) were built on MISP. There is a MISP working group coordinated by the Ministry of Civil Affairs and gathering representatives from the whole country. However, as a national emergency preparedness plan does not exist, MISP could not be integrated. Instead, MISP was integrated into RS SRH Strategy, and there is potential for similar integration in FBIH's emergency policies through the FBIH Ministry of Health. According to stakeholders, MISP had to be adapted to the local context, but it is currently a recognizable instrument and can be used as a resource and guidance in response to emergencies.

Under the GE component, UNFPA, in cooperation with FBIH health authorities, explored the **role of youth in crises**, by developing a training module on the role of youth in protection from GBV in crises. Under the PD component, two **Healthy Ageing Centres were established in floods-affected areas** in 2014.

UNFPA has directly contributed to emergency response in BiH in two major crises that occurred during the evaluation period. During and after the 2014 floods, UNFPA was able to quickly mobilize 96,300 USD from UNFPA Emergency Response Fund for response to the priority needs of affected communities within a short time frame, as well as 300,000 EUR for recovery purposes. According to stakeholders, MISP was applied during the floods. UNFPA support included a rapid post-floods assessment of health facilities, the provision of RH kits and hygiene kits for older persons, vulnerable population as well as for the overall population, and provision of mobile health units. Majority of stakeholders said that UNFPA responded in a quality and timely fashion to emergency during and after May 2014 floods, being the first UN agency on the ground to deliver dignity items. Some delays were reported in the delivery of mobile health units, due to administrative import issues.

According to COARs and stakeholders, UNFPA was very quick to respond to the migrant crisis that emerged in 2018 by deploying one surge specialist for GBV in emergencies to the field in Una-Sana Canton, backstopped by senior management team who is also on the international surge roster of experts in emergencies (Representative and Assistant Representative). This was preceded by a rapid assessment, which greatly informed future actions by specialists in the field. The specialists drafted Standard operating procedures (SOPs) for treatment of gender-based violence (GBV) victims, in cooperation with the Una-Sana Canton Ministry of Health and Social Policy, delivered trainings and awareness raising activities for humanitarian workers and other frontline workers, established safe spaces for women and girls, and organized daily activities tailored to the needs of female migrants and their cultural and other needs. In order to make this work sustainable, the SOPs have been reviewed by local experts and are expected to be adopted by cantonal authorities. SOPs have been drafted to apply to other emergency situations, not only the particular migrant crisis. At the same time, the need for a full rollout and integration of MISP across the country and relevant medical institutions remains relevant. Stakeholders have stressed that only continued work with authorities on MISP integration can guarantee relevant SRHR and GBV supplies and services in emergencies. The CO has advocated successfully for continuation of these activities, which are planned in the upcoming Joint Programme on Disaster Risk Reduction (co-funded by participating UN organizations and Government of Switzerland).

Progress toward outcome - Increased utilization of integrated SRH Services by those furthest behind

There is no available data to show whether marginalized groups have utilized integrated SRH services in BiH more; there is evidence of UNFPA CP interventions creating a basis for increased utilization of integrated SRH services, although not focusing on those furthest behind. The intended outcome of the SRHR programme area is: Increased utilization of integrated SRH Services by those furthest behind.⁶⁹ Progress toward this outcome has been assessed by analysis of effects of individual selected outputs and their effects. UNFPA has been the sole assistance provider among donor and development agencies in the areas of FP repositioning, drafting of clinical guidelines, and rolling out the BtN methodology in BiH. For this reason, the majority of progress on intended outputs can be attributed to UNFPA CP.

In terms of FP interventions as part of UNFPA CP, more specifically the delivery of FP training for family physicians, despite initial reluctance, according to UNFPA COAR 2018, family physicians have pledged after training that they would offer FP services in their daily work, especially to young people.⁷⁰ According to some stakeholders who were interviewed, the actual result of this activity is that family physicians will no longer reject giving advice to patients seeking FP advice, or give them negative statements about contraception. This was confirmed by interviewed trainees, who gave examples of the use of new/refreshed knowledge in their everyday work. Other stakeholders, however, said that FP counselling by family physicians still depended on the will, enthusiasm and affinities of individual family physicians, particularly having in mind their generally high workload and time that they can spend with patients. It was noted by some stakeholders that although they received good feedback on training and FP repositioning, there was no specific evaluation on how much this concept has been applied in practice. Also, stakeholders' views on how adapted the FP repositioning concept was to marginalized groups varied, as some said that the concept was developed as one-size-fits-all approach, while others argued that specific attention was paid to marginalized groups such as persons with disabilities, Roma, etc. For this reason, no clear conclusions could be drawn on the delivery of this part of integrated SRHR services to marginalized groups. Moreover, trainees interviewed reported that their patients were generally older persons due to chronic diseases, while younger generations usually sought services elsewhere, either in student clinics, or private health care institutions. It was noted by UNFPA staff that it was a strategic management decision not to focus on particular groups. The lack of affordable contraception has been stated as an impediment to successful rollout. This indicates that contraception is not a priority for relevant authorities, particularly as BiH is a low fertility country. There are no recent data for measurement of contraceptive use prevalence and unmet need against the baseline set in CPD 2015-2019(2020).

Another set of services that are part of the integrated SRHR package is related to Antenatal care, skilled attendance at delivery, and postnatal care and Management of obstetric and neonatal complications and emergencies. The clinical guidelines for PPH and Preeclampsia can contribute to achievement of the overall outcome for this programme area. The fact that guidelines have been developed by local professionals, with support of international experts for adaptation to best international practices, as well as the fact that guidelines have been disseminated widely could be interpreted as contributing to increased general availability of integrated SRHR services, although there is a lack of information about access of specific marginalized groups to these services. Furthermore, it is hard to link the BtN/OSRS interventions with this outcome at the moment, as the implementation of this methodology is still in nascent phase.

⁶⁹ It is understood that integrated SRHR services include Family planning/birth spacing services, Antenatal care, skilled attendance at delivery, and postnatal care, Management of obstetric and neonatal complications and emergencies, Prevention of abortion and management of complications resulting from unsafe abortion, Prevention and treatment of reproductive tract infections and sexually transmitted infections including HIV/AIDS, Early diagnosis and treatment for breast and cervical cancer, Promotion, education and support for exclusive breast feeding, Prevention and appropriate treatment of sub-fertility and infertility, Active discouragement of harmful practices such as female genital cutting, Adolescent sexual and reproductive health, Prevention and management of gender-based violence. Those furthest behind are persons with disability, people at risk of HIV infection, Roma, as well as socially excluded groups of women, men and young people.

⁷⁰ 2017 Annual Report - Bosnia & Herzegovina (UNFPA, 2018a)

It is assumed that existence of comprehensive SRH policies will contribute to increased utilization of SRHR service. Given that the RS SRH Strategy, for example, plans for cancer screening, this could contribute to one set of services in the integrated SRHR package, namely the Early diagnosis and treatment for breast and cervical cancer. However, as was noted by several stakeholders, a system for screening of breast, cervical, or prostate cancer, has not been established in BiH. In the 2013 CPE, cervical and breast cancer screening was singled out as one of promising interventions. However, apart from a needs assessment which was conducted in 2014 and colposcopy training for gynaecologists in 2016, there is no evidence of follow up on these activities in COARs. Stakeholders interviewed expressed the need for exploring options for introduction of systemic screening.

SRH policy development started to materialize more dominantly from 2017, although the work on SRH strategies had been planned a couple of years earlier and it featured in earlier financial reports. Stakeholders in RS said that SRH strategy for this entity was successfully drafted in 2018 and would be submitted for adoption in 2019. The stakeholders interviewed generally expressed satisfaction with the process of drafting of SRH strategy, UNFPA’s support and the final content of the Strategy and the accompanying Action Plan, which assesses the needs of specific target groups, including individual marginalized groups. In FBiH, a Strategic Framework for SRH was drafted for the period 2020-2026, but has not yet been adopted. The needs of marginalized groups have been taken into account in this document.

4.1.3. Efficiency

Evaluation question

EQ6. To what extent has UNFPA made good use of its human, financial and technical resources, and has used an appropriate combination of tools and approaches to pursue the achievement of the results defined in the UNFPA programme documents?

Summary findings

UNFPA demonstrates financial discipline under this component. One member of programmatic staff is shared between this and the Youth component. High quality expertise has been employed under this component, along with usage of internationally designed methodologies adapted to local context. A considerable number of activities have been implemented, with generally limited funds, and by two implementing partners delivering technical and logistical activities, to the satisfaction of beneficiaries.

UNFPA CO has limited funds for SRHR and demonstrates financial discipline. Analysis of the funds spent for selected activities in the SRHR programme area for the period 2013-2018 found that around 810,000 USD was spent on the key SRHR activities, excluding the costs of UNFPA SRHR staff and other costs. The allocated percentage of the total yearly budgets for SRHR interventions has ranged from 7 to 27 per cent of the overall budget. The budget utilization rate has been around 100 per cent for this component of the programme. There is evidence of consistency in the planning of budgets for specific interventions and expenditures, which demonstrates budgetary discipline, according to annual financial reports.

The following table illustrates UNFPA’s overall budgeting and spending on SRHR from the total budget, as well as the spending on direct activities assessed as part of this evaluation.

Table 11 Sexual and reproductive health component budget allocation and expenditure

	2013	2014 ⁷¹	2015	2016	2017	2018	Total
Allocated total	77,737	377,415	177,579	241,385	194,839	237,854	1,306,808
Spending total	75,172	376,057	174,311	236,729	194,545	235,965	1,292,778
Spending on activities	55,929	297,730	85,629	98,159	99,644	174,530	813,640

According to financial reports, the biggest amount of funds was spent over the years on emergency response. This is followed by activities for improving maternal health, family planning repositioning and development of SRH strategies. An overview of spending on individual outputs/activities is below.

Table 12 Sexual and reproductive health component expenditure by activity

	2013	2014	2015	2016	2017	2018	Total (2013-2018) in USD
Emergency response		244,926		17,067	5,725	119,939	338,657
Maternal health, including cervical and breast cancer	34,914	22,693	15,843	16,648	31,507	17,173	138,777
Family Planning repositioning	19,003	11,658	58,547	29,914	13,380	8,629	141,131
SRH strategies		18,453	7,655	11,227	21,170	13,098	71,602
Integrating MISP			3,584	23,304	24,705		51,593
Promote ICPD and SDGs in BiH					3,157	15,691	18,848
Total activities	55,929	297,730	85,629	98,159	99,644	176,548	813,640
Staff costs	38,995	71,430	80,002	91,868	76,630	110,961	469,886

These total figures, divided over six years, demonstrate economical use of resources for delivery of direct activities without UNFPA staff costs. It was confirmed by stakeholders that UNFPA has made efficient use of the little resources it has. The number of activities is high, reaching 14 in one year of the CP, 2016, and assuming a number of sub-activities.

UNFPA in BiH generally has a small programme and limited funds. Some stakeholders said that it was difficult to raise funds for interventions in the SRHR programme area as there seemed to be insufficient donor interest in this issue. More aggressive fundraising has been suggested by some stakeholders. There is evidence of CO's efforts to raise funds in the Resource Mobilization Strategies (please see Annex 3 for list of documents). However, mobilization of donors for implementation of Demographic and Health Survey has not yielded results. There are efforts to raise funds for implementation of MICS6 together with UNICEF, as well as a joint proposal for Disaster Risk Reduction (DRR) project with UNDP, UNICEF, UNESCO and FAO. The DRR project has been approved and will include UNFPA interventions related to training on and integration of MISP starting in 2019 to 2022.

⁷¹ Includes direct recovery funds.

High turnover of staff, leadership’s commitment to SRHR, and high quality expertise.

Over the period 2013-2018, the SRHR component in UNFPA CO has been led by several different people, with support of the CO leadership and support staff. Namely, CO also faced a gap in recruiting SRHR and Youth officer, which meant other staff members (notably Assistant Representative) had to take on portions of coordination of the work. Generally one technical staff has been in charge of this programme area at any given time, which is insufficient given the number of activities, particularly taking into account that one programme

Using internationally designed methodologies and adjusting them to local context. UNFPA has been using global and international documents and tools, adjusting them to BiH context with help of international and local consultants, and training local professionals to replicate knowledge gained. The evidence for this could be found in almost all selected interventions, including family planning repositioning, clinical guidelines, maternal death surveillance, MISP.

staff’s portfolio includes the Youth and Adolescents component analysed below. Interviewed stakeholders noted a high turnover of staff on this component of the UNFPA CP. Still, it was noted by a majority of stakeholders interviewed that UNFPA has managed to recruit high quality SRHR specialists as international, regional, or local consultants, who added value to the execution of activities, such as drafting of the SRH strategies, building local capacities for drafting of clinical guidelines in line with international standards and comparative best practices, introducing maternal death and near-miss surveillance, rolling out family planning in primary health care, and so on. Stakeholders also generally praised the UNFPA CO leadership for ensuring greater and maintaining consistent focus on the SRHR area. In this component, as well as others, the UNFPA presence in Banja Luka through a designated half time member of staff has been welcomed due to the achieved focus and closer communication in everyday activities. It was recommended that this support be extended to even greater presence in RS.

UNFPA CO in BiH has been delivering activities through implementing partners. In the area of SRHR, two key partners have been engaged. Partnership for Public Health has been in charge of delivering several interventions together with UNFPA CO, including FP repositioning, developing clinical guidelines, facilitating establishment of maternal mortality surveillance, and integrating MISP into emergency preparedness, among other activities. Association XY has been in charge of facilitating drafting of SRH strategies in RS and F BiH, as well as individual advocacy activities. Stakeholders have generally welcomed assistance by implementing partners, their logistical and technical support. The engagement of two implementing partners, rather than more, is plausible from the aspect of efficiency of management, organization of activities and institutional memory preservation over the years. It should be noted that there is a shortage of well equipped civil society organizations in the health sector, while UNFPA has managed not only to select relevant partners, but also to contribute to their further capacity building.

4.1.4. Sustainability

Evaluation questions
EQ7 Are programme results sustainable in short and long-term perspectives? NB: 3 years or less = short term. More than 3 years = long term.
EQ8 To what extent have the partnerships established by UNFPA promoted the national ownership and sustainability of supported interventions, programmes and policies?

Summary findings
Good prospects of short and long-term sustainability have been ensured through policy/strategy making, training, development of tools, and ownership by health authorities to some extent. Formal partnerships between UNFPA and domestic institutions/organizations have not been signed, but there is evidence of health authorities participating in policy making processes and development of procedures, as well as their dissemination. There is limited evidence of funds allocation by domestic authorities and integration of M&E mechanisms as guarantees for sustainability of results.

SRHR interventions have potential of becoming sustainable, but follow up actions are still necessary to guarantee sustainability. All interventions in the SRHR programme area have potential of being sustainable in the short term (3 years or less) and long term (greater than three years). This is because either policies were developed (e.g. SRH strategies), guidelines were made and disseminated (e.g. PPH and Preeclampsia guidelines), instruments and methodologies were introduced (e.g. MISP, BtN/OSRS), or trainings were conducted (e.g. FP). However, sustainability has not been ensured for every intervention and every result equally, so their sustainability remains subject to follow up activities either by UNFPA, or local beneficiaries.

RS SRH Strategy is expected to be sustainable in both the short and long term as it covers the period of 10 years. It was drafted by local stakeholders with a confirmed commitment of RS authorities. The domestic ownership of this policy is guaranteed thanks to UNFPA's partnership with the Ministry of Health and Social Welfare of Republika Srpska. There are key assumptions for implementation of this comprehensive document, including an action plan for implementation and monitoring indicators. There is some scepticism among stakeholders that policies in the area of SRHR will be consistently implemented, for at least two reasons: SRHR is not a priority policy, and sufficiency of funds allocated for implementation of policies is questionable. The FBIH SRH Framework Plan (draft) also covers the period of seven years and ownership by the FBIH Ministry of Health is evidenced. The Plan contains indicators of success as well as a projection of the cost of implementation.

FP repositioning could have potential for sustainability given that knowledge has been transferred to a large number of family medicine doctors. However, it is uncertain to what extent these doctors will consistently use the knowledge gained, as this could depend on personal choices, affinities, and enthusiasm. It is clear that the awareness of family medicine doctors on FP has been raised, but it is hard to expect that their counselling will be guaranteed unless FP is a part of continuous training of family doctors, unless there are clear and visible procedures for counselling, and unless procedures and results of counselling are regularly monitored and periodically evaluated, with recommendations for actions for improvement. Furthermore, it is hard to imagine sustainability and effectiveness of FP counselling without access to affordable contraceptives, which has not been achieved in BiH.

Concerning maternal health, clinical guidelines that have been developed and disseminated are a lasting resource. Both the FBIH Agency for Quality and Accreditation in the Health Sector and the RS Agency for Certification, Accreditation and Improving Quality of Health Care have participated in the development and endorsement of guidelines, together with other local professionals, who have been trained as a group to draft clinical guidelines. Ownership and use of the guidelines are likely to be sustained, as, according to stakeholders, they protect practitioners from professional mistakes. Further, sustainability could be ensured with further promotion and dissemination of guidelines. One particular activity did not demonstrate sustainability, and that is the intervention exploring options for cervical and breast cancer screening. Although promising in 2013, this activity was not followed up, while the interviewed stakeholders said that options should be considered for introduction of systemic and regular screening on cervical, breast and prostate cancers. According to CO, the reason for suspension of activity was lack of funding.

The maternal mortality surveillance system is still in nascent phase in BiH, and it is not certain what the future piloting in FBIH and RS clinics will show. Because the system has not been established in BiH yet, it is not possible to assess its sustainability. The first step remains to ensure a commitment of authorities in FBIH and RS to and ownership of a maternal mortality and morbidity surveillance system.

MISP has not been integrated into emergency preparedness plans, but MISP procedures have been developed and the health authorities can avail themselves of this resource in case of emergency. There is one MISP trainer in BiH, as well as an informal working group coordinated by BiH Ministry of Civil Affairs, which developed a MISP Readiness Action Plan 2019-2021, indicating three-year sustainability. However, more remains to be done to integrate MISP into emergency preparedness plans across BiH.

Domestic health authorities have potential to maintain institutional memory and follow up on UNFPA interventions. One noteworthy observation gained through this evaluation is a low turnover of staff in relevant institutions in the SRHR programme areas. Although this cannot be guaranteed in the future, the fact that generally the same individuals have been holding important policy positions in the FBiH Ministry of Health and RS Ministry of Health and Social Welfare, FBIH Agency for Quality and Accreditation in the Health Sector and the RS Agency for Certification, Accreditation and Improving Quality of Health Care, and even relevant CSOs (including the implementing partners) for a number of years. This has contributed to institutional memory, continuity of actions and interventions, and general availability for follow up in order to ensure sustainability of actions in the SRHR area.

UNFPA is a valued and trusted partner. UNFPA has not signed formal partnership agreements with authorities in BiH in the area of SRHR. In this programme area, the Health Ministries have been the key counterparts, but apart from them, the BiH Ministry of Civil Affairs, the Public Health Institute of RS and Public Health Institute of FBiH, the FBIH Agency for Quality and Accreditation in the Health Sector and the RS Agency for Certification, Accreditation and Improving Quality of Health Care, as well as implementing partners and international associates (e.g. South-Eastern European Health Network, UNICEF, WHO) have also been recognized as the key partners in the Partnership Plans. All SRHR stakeholders interviewed said that they valued their partnership and cooperation with UNFPA.

4.2. Youth and adolescents

4.2.1. Relevance

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

Summary findings
Under this component, the UNFPA programme has been largely adapted to the needs of youth, including Roma youth. The programme has been largely adapted to international policy frameworks, UNFPA strategic plans, and the UNDAF. The programme does not make specific reference to existing domestic youth policies, but youth needs are identified. UNFPA successfully responded to the 2018 migrant crisis by delivering activities targeting youth. While in the previous CPD, UNFPA worked on developing a system for tracking emigrations in order to use such statistics for policy development, currently youth emigration has not been reflected in the CPD 2015-2019 (2020) UNFPA programme.

There is evidence that the UNFPA programme has been adapted to some extent to different needs of different groups of population, in this case youth, but not of marginalized and vulnerable populations. Youth feature in the CPD 2010-2014 as one of the target groups under the outcome related to SRHR, which focuses on health, health education and family planning policies and services that are inclusive of the older persons, women, youth, and people at risk of HIV infections, as well as socially excluded sub-groups of some of these populations (youth and women). The CPD 2015-2019(2020), however, singles out a specific component focusing on youth and adolescents. The emphasis on youth in CPD 2010-2014 is placed because of evidence of social exclusion, as cited in this document, but also because of lessons learned from the past, mostly regarding sexual education (non-existent in schools at the time, but good peer education initiatives had been noted).

The CPD 2010-2014 does not make specific reference to different categories of youth populations to mainstream the human rights and gender equality approach, e.g. by integrating girls, Roma, youth with disabilities. The 2013 CCA found that “further efforts should be made to support life-skills based

education, including information on sexuality, reproduction and safe sexual practices, as well as entrepreneurial learning for adolescents and youth. In addition, the UN can support better involvement of young people in policy dialogue and decision-making. Future efforts may also consider supporting BiH authorities and civil society to implement specific behaviour changing activities targeting out-of-school youth, with a focus on Roma and other at-risk population groups.⁷² This view has been taken into account in CPD 2015-2019(2020), which finds that there are no coherent youth policies and strategies, that youth face high unemployment (particularly rural youth, Roma, youth with poor schooling or disabilities), that young Roma tend to marry very early, even before the age of 15, that one in three Roma girls give birth before the age of 15. It was also noted that youth and adolescents have poor knowledge about SRHR and that comprehensive sexuality education was not available across the country. MICS data for general youth knowledge of SRHR and access to SRHR services was not quoted in this CPD. There is evidence that UNFPA conducted relevant assessments in this focus area during the CP. Namely, a survey on Youth Views on CSE as a Part of Formal Education was conducted to inform UNFPA activities.⁷³ Interviews with stakeholders who are familiar with this programme area suggested that the programme was largely aligned with the needs of youth and adolescents, although they rarely singled out alignment with sub-categories of youth population, particularly those furthest behind. COARs provide evidence of interventions targetting youth, but largely general youth population, with some evidence of activities addressing Roma girls.

Concerning application of human rights approach to CP design and implementation, both CPDs draw attention to marginalized groups in the area of SRHR, while in the area of Youth and Adolescents the human rights of youth and adolescents are emphasized in the definition of the key output in the CPD 2015-2019(2020) “increasing national capacity to conduct evidence-based advocacy for incorporating the human rights and needs of adolescents and youth in national laws, policies, programmes, including in humanitarian settings”. Specific gender mainstreaming actions are reflected in the defined approach to delivery of interventions under this outcome in CPD 2015-2019(2020), e.g. development and implementation of gender-sensitive sexual and reproductive health and rights-related strategies on youth, with focus on disadvantaged groups, and addressing early marriages and early onset of sexual life among Roma girls and boys, including Roma teen pregnancies.

UNFPA programme is mostly aligned with international policy frameworks, while there is limited evidence that national policy frameworks and changing local context have shaped CP. According to the UNFPA Strategic plan 2014-2017, “Women, adolescents and youth are the key beneficiaries of UNFPA work”. Three desired outputs of UNFPA Strategic Plan 2018-2021 target youth and adolescents, including girls. The CPD 2015-2019(2020) reflects these priorities. Evidence of specific and relevant interventions was found in AWP and COARs, more specifically, support to drafting of youth policies in RS and FBiH, working to introduce comprehensive sexual education, initiatives to prevent early marriages among Roma, and attempts at establishing a joint work platform for UN agencies in BiH on youth issues.⁷⁴

UNFPA CPDs do not quote the ICPD goals but they are reflected in the CP. In the area of Youth and Adolescents, the interventions are clearly in line with the ICPD objectives related to children and youth, including youth participation in policy making, youth access to SRHR services and education, and elimination of child marriages.⁷⁵ SDGs were not adopted at the time of CPD drafting and approval. However, some UNFPA interventions in this programme area are pertinent to SDGs (please see Table 9 Overview of SDGs and targets relevant for UNFPA CP).

UNFPA programme is aligned with priorities set in UNDAF for the periods 2010-2014 and 2015-2019(2020). It should be noted that, although youth feature as one of target groups under the Social Inclusion outcome of UNDAF, some stakeholders said that this group of population deserved greater

⁷² *Common Country Assessment Bosnia and Herzegovina 2013* (United Nations Country Team, 2013, str. 45)

⁷³ *Youth Views on Comprehensive Sexuality Education as a Part of Formal Education* (proMENTE social research, 2017)

⁷⁴ These interventions correlate to Outcome 2, Outputs 1, 2, 3 from the Strategic Plan 2014-2017 and Outcome 2, Outputs 1, 2 and 3 from the Strategic plan 2018-2021.

⁷⁵ *Programme of Action* (United Nations Population Fund, 2004)

and specific attention in this partnership document. According to stakeholders, UNFPA was the first to acknowledge this and initiated establishment of a UNCT Youth Task Force.

When it comes to alignment with domestic policy frameworks, the CPD 2010-2014 quoted the Social Inclusion Strategy (2008-2013), while the subsequent CPD said that coherent youth policies and strategies are not in place. The CPDs do not make reference to at least two youth policies that have been in force in RS covering the periods 2006–2010, 2010–2015⁷⁶ and matching the periods of UNFPA programming, or relevant RS youth legislation.⁷⁷ Stakeholders interviewed have generally confirmed relevance of this programme area in relation to the needs of youth, recognizing a lack of relevant domestic youth and other policies in some jurisdictions within the country, but also noting that youth-related work should go beyond health issues.

In this area of intervention, there has been one major change in the domestic context, although not necessarily confirmed by evidence. This change is related to youth emigration. This was observed by UNFPA through population data and other sources monitoring, but this has not been mentioned directly in the CPD. The joint UN youth programming, which is still in its nascent phase, could be an opportunity to take into account this issue of youth emigration related to youth population.

4.2.2. Effectiveness

Evaluation questions
EQ3. To what extent have the intended programme outputs been achieved? To what extent did the outputs contribute to the achievement of these planned outcomes: increased the access of young people to quality SRH services and sexuality education, and what was the degree of achievement of the outcomes?
EQ 4 To what extent has UNFPA contributed to an improved emergency preparedness in BiH, and in the area of maternal health / sexual and reproductive health including MISP?
EQ5 To what extent has the CO been able to respond to emergency situations in its Area of Responsibility (AoR), if one was declared? What was the quality and timeliness of the response?

Summary findings
UNFPA has partly achieved the outputs related to youth policy drafting and adoption and introducing comprehensive sexuality education in schools; it has fully met the targets related to addressing child marriage, while peer education programmes were stopped due to lack of sustainability prospects. Interventions related to sexuality education and youth policies could gradually lead to increased access of young people to sexuality education, while the access to services yet remains to be assessed. Improved emergency preparedness has not been addressed under this component. Although under GE component, UNFPA has explored the role of youth in crises, by developing a training module on the role of youth in protection from GBV in crises.

Achievement of outputs

In order to assess the extent to which the intended programme outputs have been achieved over two programming cycles, a selection of comparable outputs has been made. These outputs are “Service providers in the health, education, social protection and judiciary sectors have improved knowledge and skills to increase the access of youth and women to high-quality services, and to empower them to make decisions on sexual and reproductive health” from the CPD 2010-2014 and “Increased national capacity to conduct evidence-based advocacy for incorporating the human rights and needs of adolescents and youth in national laws, policies and programmes, including in humanitarian settings” from the CPD 2015-2019(2020). The targets set for these outputs are the following: 1. Number of peer education clubs

⁷⁶ *Omladinska politika Republike Srpske od 2006. do 2010. godine* (Government of Republika Srpska, 2006), *Omladinska politika Republike Srpske od 2010. do 2015. godine* (Government of Republika Srpska, 2009),

⁷⁷ (Zakon o mladima, 2011)

in schools, 2. Number of policies or programmes at state and entities level that address or include marginalized adolescents and youth needs, 3. Percentage of secondary (changed to primary) schools that introduce comprehensive sexuality education aligned with international standards, and 4. Number of country-wide civil society initiatives addressing adolescent girls at risk of child marriage.

No evidence that number of SRH peer education clubs increased (target 1). Support to peer education on SRHR is an activity under the CPD 2010-2014. In this CPD, it was reported that previously UNFPA had supported peer education and counselling for youth on SRHR and it was concluded that this practice should be replicated and the number of peer education clubs in schools increased from the baseline of 24 to 34. There does not seem to be evidence that this target was achieved and that earlier work had been replicated. In the 2014 COAR, UNFPA reported that the overall situation was challenging, as the NGO-provided peer education has not been institutionalized.

Introducing comprehensive sexuality education partly achieved (target 3) UNFPA launched an initiative to review the Healthy Lifestyles Curriculum, which has been introduced in the Sarajevo Canton earlier, to check it against international standards. Only after this effort, was the opportunity for expansion to another canton in FBiH seized. According to interviews with stakeholders and UNFPA COARs, the integration of Youth Health subject into primary school curricula in the Bosnian Podrinje Canton has been very successful during the period 2016-2018. This was a well thought out process, where the education authorities in the Bosnian Podrinje Canton did not want to replicate the model from the Sarajevo Canton by default, but decided to make choices adapted to their needs and policies and to make this subject compulsory and taught by head teachers for the 6th to 9th grades. The Association XY, as UNFPA's implementing partner, supported the process of drafting the syllabus and guide for teachers, and delivered training to head teachers. The trainees interviewed gave excellent grades for the training delivered and said that they were already implementing the Youth Health subject in the academic year 2018/2019. UNFPA commissioned a survey on Youth Views on CSE as a Part of Formal Education from December 2017,⁷⁸ which also surveyed young people's knowledge of SRHR. The survey findings suggested that the Internet was the common source of knowledge in this area, followed by peer education, and teachers. Almost all respondents said that reproductive health should be taught at school. This was confirmed during FGD with youth as part of this evaluation. The findings of the aforementioned survey have been used for planning of specific interventions, including making of web platforms providing information about sexual and reproductive health (<http://www.spolnozdravlje.ba> for FBiH and <http://www.sveos.info/> for RS and organizing a hackathon to develop an SRHR-related smartphone application. It should be noted that the proposed RS Strategy for Improvement of Sexual and Reproductive Health envisages strengthening of formal or informal education of children and youth about sexual and reproductive health based on evidence, along with a number of other awareness raising actions, with special focus on protection of health and rights of marginalized groups. Also, the FBiH strategic documents in this field (FBiH Strategy for the Improvement of Sexual and Reproductive Health 2010-2019 and Strategic Programme Framework for Improvement of Sexual and Reproductive Health 2020-2026) also envisage increasing knowledge and promotion of informed decision-making on sexual and reproductive health and rights, particularly among women, youth and marginalized groups. Analysis of UNFPA's advocacy and partnership plans suggests that UNFPA's efforts to replicate CSE integration into school curricula across the country have not been ambitious enough. The target set in the CPD 2015-2019(2020) is 13 per cent of secondary schools, which was replaced by 13 percent of primary schools given the importance of early learning. Current coverage (meaning all primary schools in Sarajevo Canton and Bosnian Podrinje Canton out of all primary schools in BiH) is 5.61%, hence partly achieved.

Youth policy drafting and adoption partly achieved (target 2) When it comes to support to development of policies that address youth and adolescent needs, UNFPA supported the drafting of youth policies for RS and FBiH, (that is, the Youth policy RS 2016-2020 and Strategy for Youth FBiH 2016-2020). RS successfully adopted the Youth policy in 2016.⁷⁹ FBiH has yet to pass the youth policy

⁷⁸ *Youth Views on Comprehensive Sexuality Education as a Part of Formal Education* (proMENTE social research, 2017)

⁷⁹ *Omladinska politika Republike Srpske od 2016. do 2020. godine* (Government of Republika Srpska, 2016)

and the CO has worked on advocating document adoption with the relevant ministry. However, given the delays in adoption, the draft strategy has become outdated. According to COARs, both documents contain relevant information on SRHR and CSE. This was confirmed by interviewed stakeholders, who said that UNFPA insisted on several key aspects of policy drafting, most notably the focus on education, SRHR and gender equality, and engagement of youth in policy drafting. According to stakeholders, UNFPA made sure that the voices of youth were heard and represented in the strategy development, through bringing in an international expert, as well as funding the conferences with youth. Looking at the targets set under CPD 2015-2019(2020), the target of having two pertinent policies has been met, but the target does not specify whether these policies need only to be drafted or also adopted by authorities. The UN Youth Strategic Document could be understood as another policy development intervention in which UNFPA participates. UNFPA has commissioned mapping exercise and consultant recommendations for joint UN youth work.

Output related to addressing the risk of child marriage achieved (target 4) A specific intervention, which is in line with international policy frameworks and UNFPA strategic plans, which carries an innovative element in UNFPA CP, is related to prevention of early marriages. This activity has stretched over three years, from 2014 to 2016, including training and script writing, according to COARs. It has resulted in cooperation with UNICEF and the organization of 11 theatre plays in two schools with predominantly Roma children. The stakeholders said that the plays increased awareness of early marriages in Roma population, but the effects on delaying marriages were not certain and these activities required more systemic follow up. However, the target of having two civil society initiatives has been met.

Progress toward outcomes - Increased access of young people to quality SRH services and sexuality education

Interventions related to sexuality education could gradually lead to increased access of young people to sexuality education, while development of a youth friendly approach to provision of services by primary health care providers is yet to be tested in terms of effective access to SRHR health services. Two outcome indicators from two CDPs are relevant for this outcome, one related to the number of municipalities with established multi-disciplinary referral mechanisms targeting socially excluded groups (CPD 2010-2014) and another related to policies in place addressing SRHR needs of youth and adolescents, including marginalized youth (CPD 2015-2019(2020)). The COARs do not indicate the number of municipalities with established multi-disciplinary referral mechanisms. For this reason, it is unknown to what extent youth's access to quality SRHR services and sexuality education has increased or decreased. When it comes to the policies in place addressing SRHR needs of youth and adolescents, the target was two policies without specifying whether these policies were supposed to be only developed, or their adoption ensured. There is evidence that one policy has actually been endorsed, which is the RS Youth Policy. However, it could be argued that, although the FBIH Youth Strategy has not been adopted, the methodology for its drafting has been replicated in individual cantons, as a spillover and unintended effect of the FBIH Youth Strategy drafting. According to stakeholders, youth policies have been adopted in two cantons, the USK and ZDK, while the passage of a youth strategy in the Sarajevo Canton was disrupted by the election cycle in 2018.

When it comes to access to sexuality education, youth's access has certainly increased as the subject Youth Health has been formally integrated as an obligatory educational content for the grades 6th to 9th in primary schools of the Bosnian Podrinje Canton. Moreover, the intervention relating to creation of a web platform on sexual health is promising, but its effects are yet to be measured. The theatre plays on early marriage are expected to have increased awareness on this topic, although it is unknown to what extent early marriages have been delayed.

Concerning youth's actual access to SRHR services, UNFPA has reported in the COARs 2016, 2017 and 2018 that a youth friendly approach module was piloted for training of primary health care providers. A number of stakeholders have pointed out, however, that integrating SRHR services for youth into regular family medicine services is not an effective approach because youth choose to seek

advice and services in places different than their parents and families. They have argued for support to establishment of specialized youth SRHR services. On the other hand, there are views that youth could be stigmatized if accessing SRHR services specifically designated to them. Also, stakeholders argued that effective linkages should be established between the education and health systems in terms of provision of SRHR services to youth.

UNFPA has not been the sole assistance provider among donor and development agencies in the areas of Youth and Adolescents and pertinent activities. Most notably, UNFPA’s contribution to the drafting of the FBIH Youth Strategy constituted only a smaller portion of a larger project funded by the EU and implemented by the Institute for Youth Development KULT and OKC (Youth Communication Centre),⁸⁰ Also, in the area of CSE, UNFPA has followed up on Association XY’s previous work in Sarajevo Canton, but the effects in Bosnian Podrinje Canton could be attributed largely to UNFPA CP. Moreover the intervention related to theatre plays on early marriages has been delivered in cooperation with UNICEF. However, according to stakeholders UNFPA has been often approached by youth partners in order to give weight to discussions concerning youth development.

4.2.3. Efficiency

Evaluation question
EQ6.To what extent has UNFPA made good use of its human, financial and technical resources, and has used an appropriate combination of tools and approaches to pursue the achievement of the results defined in the UNFPA programme documents?

Summary findings
UNFPA has limited and unstable funds for this component, which affects the coverage and effects of activities. UNFPA demonstrates financial discipline under this component. This component has been underfunded in relation to SRHR and GE components. One member of programmatic staff is shared between this and the SRHR component. Relevant implementing partners have been selected to deliver a rather small number of activities. Internationally recognized methodologies and innovative approaches have been utilized in youth education.

UNFPA CO has limited and unstable funds for this component, which affects the coverage and effects of activities. Analysis of the funds spent for selected activities in this programme area for the period 2013-2018 found that around 240,000 USD was spent on these activities, excluding the costs of UNFPA SRHR staff and other costs. The allocated percentage of the total yearly budgets for interventions in this programme area has ranged from 2 to 15 per cent of the overall budget. In the years when 15 and 13 per cent of the budget was allocated to this component (2014 and 2015 respectively), the biggest amount of funds was actually spent on MISP in 2014. In other years, the percentage of budget allocated and spent on this component ranged from 2 to 5 per cent. The overall utilization rate for this component has ranged from 94 to 100 per cent. There is no full consistency in the planning of budgets from year to year. For example, the planned budget increased by four times in 2014 in relation to 2013 and by three times in 2015 in relation to 2013, in order to drop to 1/7 of the 2015 budget in 2016 and remain unstable for two consequent years. The spending in 2014 and 2015 could be explained by the emergency situation caused by floods in BiH.

The following table illustrates UNFPA’s overall budgeting and spending on Youth and Adolescents from the total budget, as well as the spending on direct activities assessed as part of this evaluation.

Table 13 Youth and adolescents component budget allocation and expenditure

	2013	2014	2015	2016	2017	2018	Total
Allocated total	50,862	217,103	155,886	21,400	37,735	74,859	557,845
Spending total	49,146	215,492	150,265	20,181	37,812	73,883	546,780

⁸⁰ Institute for Youth Development – KULT and OKC implemented a three-year project from January 2014, with support of EU funds through the EIDHR Program (European Instrument for Democracy and Human Rights).

Spending on activities	19,436	70,986	58,953	17,618	32,290	43,254	242,537
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According to financial reports, the biggest amount of funds was spent over the years on youth policies, followed by comprehensive sexuality education activities and peer education clubs. This is followed by activities on prevention of early marriages. An overview of spending on individual outputs/activities is below.

Table 14 Youth and adolescents component expenditure by activity

	2013	2014	2015	2016	2017	2018	Total (2013-2018) in USD
Youth policies		7,907	51,336	2,515	15,667	1,661	79,086
CSE		25,739	6,136	9,359	5,936	22,388	69,557
Peer education clubs	19,436	37,341					56,776
Early marriage prevention			1,481	5,743	10,686		17,911
Youth friendly approaches						8,577	8,577
Youth programming						10,629	10,629
Total activities	19,435	70,986	58,953	17,618	32,290	43,254	242,537
Staff costs	28,902	54,939	78,341	324	3,155	0	165,660

The financial information suggests very limited budgets for this component of CP and no basis for ambitious and larger scale interventions. It was confirmed by stakeholders that UNFPA has made efficient use of the small resources available.

Turnover of staff; technical staff shared between SRHR and Youth; relevant implementing partners. Over the period 2013-2018, the Youth and Adolescents component in UNFPA CO has also experienced changes of staff, which, according to stakeholders required some adjustment time. It was noted by stakeholders that UNFPA needed to have more staff, if they were willing to work across a number of intervention areas, including youth and adolescents. One technical staff in UNFPA is in charge of this and SRHR component activities. UNFPA has selected relevant partners for delivery of activities (KULT, OKC, Association XY, among others), with a proven ability and track record in delivering youth-related interventions related to policy, participation, or education, in line with its Resource Mobilization Plans.

Only a small portion of UNFPA's budget has been spent on the component of Youth and Adolescents. Given the number and reach of activities, it can be argued that the activities were generally contributing to achieving the outcome. However, the COARs and financial reports indicate that UNFPA was struggling among competing priorities and able only to allocate funds for isolated, rather than systemic activities. For example, having to focus on one canton for integration of CSE, instead of aiming to replicate this policy and practice even further, or organizing one off theatre plays on early marriages in absence of funds for more systemic response to the issue. On the other hand, systemic efforts to develop youth policies have been praiseworthy, but proved to be at risk of a lack of will of authorities, at least in FBIH, to adopt new policies. With the exception of the 2015 Resource Mobilization Plan, which demonstrates an ambitious approach to mobilizing funds for Youth and SRHR, youth policies, and work with marginalized groups, subsequent RMPs focus on mobilization of funds for DHS or MICSs (which cover other target groups apart from youth) and some new areas of intervention such as youth, peace and security (Please see Annex 3 for list of documents). Attempts at fundraising were made but with no success.

From the budget review, it could be concluded that a good share of funds for selected activities was spent on technical expertise provided by individual experts. Also, from annual reports and interviews

with stakeholders, it is clear that UNFPA has been reviewing local policies and practices to align them with international standards (e.g. CSE curriculum review, and methodological support to youth policy development). Also, UNFPA has been innovative, together with UNICEF, in organizing theatre plays on early marriages as a youth-friendly approach for at-risk groups. Stakeholders and training participants have praised the approach taken to delivering of CSE training to primary school teachers in the Bosnian Podrinje Canton.

4.2.4. Sustainability

Evaluation questions
EQ7 Are programme results sustainable in short and long-term perspectives? NB: 3 years or less = short term. More than 3 years = long term.
EQ8 To what extent have the partnerships established by UNFPA promoted the national ownership and sustainability of supported interventions, programmes and policies?

Summary findings
Adopted policies show good prospects of sustainability in the short and long-term, but funding and monitoring of implementation needs to be ensured. Training of teachers in CSE is likely to ensure sustainability of results, as well as sexuality education tools, such as specifically designated website and smartphone application, if their maintenance is taken over by domestic partners. No formal partnerships have been signed with domestic authorities. The child marriage initiative does not show evidence of sustainability.

Prospects of sustainability of interventions in this programme area vary depending on institutions' ownership and coverage of activities. The policy development is expected to be sustainable in the short term (3 years or less) with the passage of the RS Youth Policy 2016-2020. According to stakeholders, the line ministry has been monitoring the implementation and issuing calls for project proposals for implementation of youth policy measures, but more actors need to engage in both implementation and monitoring, in order to ensure that more resources and from different sectors contribute to implementation of this multidisciplinary policy. On the other hand, the fact that the FBiH Youth Strategy was not adopted because of failure to obtain a positive opinion of the Ministry of Finance indicates lack of even short-term sustainability of this intervention.

When it comes to theatre plays for early marriages, this intervention does not show prospects of short-term or long-term sustainability. As argued earlier, this initiative certainly increased knowledge of direct participants, but there is no guarantee that the awareness will be further raised, without follow up activities, in order to contribute to actual delay of early marriages.

A distinction should be made between peer education clubs and integration of CSE into school curricula. UNFPA noted in one of its COARs that peer education clubs organized by NGOs did not guarantee sustainability because the education was not formalized through public sector institutions. On the other hand, the fact that Healthy Lifestyles and Youth Health subjects have been integrated into primary school curricula in Sarajevo and Bosnian Podrinje Cantons indicates good prospects of at least short-term sustainability. Longer-term sustainability (more than three years) could be ensured provided further actions. There is an expressed need in the Bosnian Podrinje Canton to extend the subject to secondary schools, and to lower grades of primary school in an adjusted form, as well as to train new teachers to ensure that turnover of staff is not an obstacle to fully embedding this subject. The sustainability of current class delivery has been ensured by the commitment of education authorities and relevant educational materials, over which the education authorities hold full ownership. However, it is uncertain when cantonal authorities will allocate funds for expansion of this success.

UNFPA has not signed formal partnership agreements with authorities in BiH on this component. However, the ownership and enthusiasm of Bosnian Podrinje Canton education authorities indicates continuous sustaining of the results achieved in CSE integration. Still, there is no clear vision for the

replication of this success throughout BiH. Also, there seems to be no follow up when it comes to further promotion of FBIH Youth Strategy for adoption, or more impactful solutions for Roma girls.

4.3. Gender equality

4.3.1. Relevance

Evaluation questions
EQ1. To what extent is the UNFPA programme (i) adapted to the needs of women, adolescents and youth, people at risk of HIV infections, disabled and older persons, and Roma, (ii) and in line with the priorities set by the international and national policy frameworks, (iii) aligned with the UNFPA policies and strategies and the UNDAF as well as with interventions of other development partners? Do planned interventions adequately reflect the goals stated in the UNFPA Strategic Plan?
EQ2. To what extent has the UNFPA office been able to respond to changes in the national development context and, in particular, to the aggravated humanitarian situation in countries/territory?
Summary findings
Under this component, the UNFPA programme has been largely adapted to the needs of women, particularly victims of violence, but also to the needs of men and boys as part of gender transformative actions. The programme has been largely in line with international policy frameworks, UNFPA strategic plans, and the UNDAF. Domestic gender equality policies are not quoted in CPDs, but are consulted in the delivery of the programme. UNFPA successfully responded in two situations of aggravated humanitarian crisis - during 2014 floods and 2018 migrant crisis - by delivering activities related to GBV. UNFPA adapted its programme to diverging political views of CRSV in two entities.

There is evidence that the UNFPA programme has been adapted to a good extent to different Gender Equality (GE) needs of different groups of population, most notably women, including marginalized and vulnerable populations. The CPDs 2010-2014 and 2015-2019(2020) prioritize the outcomes related to GE focusing on two key population groups - women and men, largely in the context of gender-based violence (GBV). It is evident from the CP (AWPs and COARs) that the key target group are women who are victims of GBV and conflict-related sexual violence (CRSV). One subgroup of the male population (boys) is mentioned in CPD 2015-2019(2020), which is reflected in COARs, relating to civil society initiatives involving men and boys in addressing GBV. Other initiatives, involving and targeting youth are evident from COARs, e.g. youth theatre plays for reducing stigmatization of victims of conflict-related sexual violence (CRSV), modules on role of youth in protection from GBV. Stakeholder interviews have confirmed, however, that the CP interventions have largely focused on women, particularly victims of GBV and CRSV, as target groups. This is in line with findings of the 2013 CCA stating that “Violence against women, especially domestic violence, continues to be a widespread social problem in BiH, and is a serious violation of the fundamental human rights of victims/survivors.”⁸¹ Also, UNFPA supported the first Study on Prevalence and Characteristic of Violence against Women in BiH⁸² from 2013. This study was quoted in the CCA, and there is indication that it has been used in CPD 2015-2019(2020), but without specific reference. CPDs generally lack baseline information for CRSV, except noting that the legacy of physical and sexual abuse during the war, especially against women, still needs to be addressed.

⁸¹ *Common Country Assessment Bosnia and Herzegovina 2013* (United Nations Country Team, 2013)

⁸² This study suggested that that almost half of women in BiH older than 15 have been subjected at least once in their lifetime to some kind of violence (physical, psychological, sexual or economic) and one in ten has experienced violence in the past year. (Babović, Pavlović, Ginić, & Karadinović, Prevalence and Characteristics of Violence against Women in BiH, 2013)

The UNFPA CO has commissioned several studies to inform its planning to address GBV/CRSV as part of a Joint Programme with other agencies. The studies⁸³ informed the UNFPA CP, which was directed toward enhancing health system's response to needs of victims of GBV/CRSV, alleviating stigma, and gender transformative actions, largely through capacity building and advocacy.

Concerning application of human rights approach to CP design and implementation, CPD 2010-2014 draws attention to gender-based discrimination in BiH, with three issues of particular concern: (a) unequal representation of women in political processes; (b) access to employment; and (c) gender-based violence. The CPD 2015-2019(2020) notes persisting gender inequality and traditional gender roles, as well as widespread and unreported violence against women, and the legacy of physical and sexual abuse during war. CPD 2015-2019(2020) states that the programme will promote gender equality and empowerment of women by applying a human rights based approach and “advocating for a conducive human rights environment for empowerment of survivors of gender-based and conflict-related sexual violence”. Also, UNFPA BiH refers to the Universal Periodic Review⁸⁴ for measuring the outcome indicator for this component in relation to implementation of recommendations on reproductive rights for BiH.

The CPDs do not make specific reference to gender mainstreaming as such, but women's rights feature highly in both documents in the area of GE. There is evidence of addressing the role of male participation in ensuring gender equality in CPD 2015-2019(2020) through introducing gender-transformative approaches and strengthening the capacity of civil society organizations to engage men and boys on gender equality and gender-based violence, including the legacy of conflict related sexual violence.

UNFPA programme is mostly aligned with international and national policy frameworks and has been able to adapt to changing local context related to GE. UNFPA CPDs for BiH reflect clearly the goals, outcomes and outputs from UNFPA Strategic Plans.⁸⁵ However, the focus varies to some extent. While the CPD 2010-2014 focuses on the outcome “Security sector and law enforcement sector agencies integrate gender equality issues and mainstream gender into their policies and protocols, including those on gender-based violence”, the CPD 2015-2019(2020) defines the pertinent outcome as “Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth”. The CP outputs vary accordingly over the years of CPD implementation, with the emphasis moving from interventions in the security sector to those in the health sector and civil society.

UNFPA CPDs do not quote the ICPD goals in the area of GE, but they are reflected in the CP. In the area of GE, the interventions are clearly in line with the ICPD objectives related to Empowerment and status of women and Male participation and responsibility, including Eliminating all practices that discriminate against women; assisting women to establish and realize their rights, including those that relate to reproductive and sexual health and Eliminating violence against women.⁸⁶ SDGs were not adopted at the time of CPD drafting and approval. However, some UNFPA interventions in GE are pertinent to SDGs (please see Table 9 Overview of SDGs and targets relevant for UNFPA CP).

UNFPA programme in the area of GE is aligned with priorities set in the UNDAF for the periods 2010-2014 and 2015-2019(2020). In both periods, UNFPA featured as a partner of other UN agencies in planning how to achieve UNDAF priorities related to Rule of Law and Human Security, Social

⁸³ *Stigma against Survivors of Conflict-Related Sexual Violence in Bosnia and Herzegovina - Research Summary* (UNFPA, 2015a), *Survey on Perceptions, Attitudes and Opinions of Medical and Social Services Professionals towards Gender Based Violence and Conflict Related Sexual Violence Issues and Survivors* (UNFPA, 2014), and *Masculinities and Gender-Based Violence against Women in Bosnia and Herzegovina. A Qualitative Study* (Alvarez Minte & Gaković Hrasnica, n.d.).

⁸⁴ The Universal Periodic Review (UPR) is a unique process which involves a review of the human rights records of all UN Member States (<https://www.ohchr.org/en/hrbodies/upr/pages/uprmain.aspx>)

⁸⁵ The interventions 3 to Outcome 1, Outputs 1 and 2 from the Strategic Plan 2014-2017 and Outcome 3, Outputs 1, 2 and 3 from the Strategic plan 2018-2021.

⁸⁶ *Programme of Action* (United Nations Population Fund, 2004)

Inclusion, and Empowerment of Women, for which UNFPA's interventions in the area of GE are relevant.

In line with the nature of interventions, the alignment with international and national priorities has changed over years. The CPD 2010-2014 quotes the National Small Arms and Light Weapons (SALW) Control Strategy and "national law on disaster management and preparedness" in the GE component, as well as the United Nations Security Council resolution 1325 on women, peace and security. The CPD 2015-2019(2020) refers to the Concluding Observations of the United Nations Committee on the Elimination of Discrimination against Women. In terms of national policies, this CPD, as well as the previous one, fails to refer to the Gender Equality Law,⁸⁷ the Gender Action Plans,⁸⁸ or the strategies for prevention family violence,⁸⁹ including UNFPA's previous efforts to draft and advocate the Programme for Improvement of Status of Women Victims of Conflict Related Sexual Violence and Torture in BiH.⁹⁰ However, this does not necessarily mean that these international and national policies have not been taken into account in delivery of interventions. Namely, it is reported by UNFPA that in the joint programming for Seeking Care, Support and Justice for Survivors of Conflict Related Sexual Violence in BiH, the priorities from CEDAW,⁹¹ UNSCR 1325 Action Plan for BiH⁹² and GAP BiH have been taken into account. Stakeholders have confirmed that delivery of interventions in the area of establishment of referral mechanisms have contributed to implementing obligations under BiH's Framework Strategy for implementing the Istanbul Convention.⁹³

UNFPA has been able to adapt to different policy stances of different partners in BiH with regard to specific areas of GE related interventions. For example, it was agreed with the RS Ministry of Health and Social Welfare that the health sector's response to victims of GBV should be looked at comprehensively, and not single out any group of GBV victims, including victims of CRSV.

The biggest changes in the national development context occurred at times of specific crisis, most notably during the 2014 floods and 2018 migrant crisis. According to staff and stakeholder interviews, as well as COARs, UNFPA has been able to respond to these changes by mobilizing resources to address the country's newly emerging needs. Building capacities of relevant stakeholders for protecting women in emergencies has been foreseen as specific intervention. This intervention was elaborated under the SRHR component as discussed above.

⁸⁷ (Law on Gender Equality in Bosnia and Herzegovina, Consolidated Version, 2010)

⁸⁸ *Gender Action Plan of Bosnia and Herzegovina (GAP)* (Gender Equality Agency of Bosnia and Herzegovina, Ministry of Human Rights and Refugees of Bosnia and Herzegovina, 2007), *Akcionni plan za implementaciju UNSCR 1325 u Bosni i Hercegovini za period 2014.-2017. godine* (Gender Equality Agency of Bosnia and Herzegovina, Ministry of Human Rights and Refugees of Bosnia and Herzegovina, 2013)

⁸⁹ *Strategija za prevenciju i borbu protiv nasilja u porodici (2013-2017)* (Gender centar Federacije Bosne i Hercegovine, 2013), *Strategija za borbu protiv nasilja u porodici u Republici Srpskoj do 2013. godine* (Republika Srpska. Vlada, 2010), *Strategija za suzbijanje nasilja u porodici Republike Srpske (2014-2019)* (Republika Srpska. Vlada, 2014)

⁹⁰ *UNFPA Activities on Combating Sexual Violence in Conflict* (UNFPA, 2012)

4.3.2. Effectiveness

Evaluation questions
EQ3. To what extent have the intended programme outputs been achieved? To what extent did the outputs contribute to the achievement of these planned outcomes: mainstreaming of provisions to advance gender equality, and what was the degree of achievement of the outcomes?
EQ 4 To what extent has UNFPA contributed to an improved emergency preparedness in BiH, and in the area of maternal health / sexual and reproductive health including MISP?
EQ5 To what extent has each office been able to respond to emergency situations in its Area of Responsibility (AoR), if one was declared? What was the quality and timeliness of the response?
Summary findings
UNFPA has met the target of integrating GBV prevention, protection and response into national sexual and reproductive health programmes. It has partly met the target of three civil society initiatives involving men and boys in addressing GBV. The target of establishing a tracking and reporting mechanism on reproductive rights recommendations has not been met. One of the unintended outputs in relation to the CPD was the stigma alleviation initiative. GBV prevention, protection and response outputs have contributed to gender mainstreaming in the health sector, while other activities have been aiming at changing attitudes toward gender equality. Under this component, treatment of GBV victims in crises has been addressed through development of knowledge and operational products. UNFPA has directly responded to an emergency during the 2018 migrant crisis through GBV interventions (elaborated under SRHR above).

Achievement of outputs

In order to assess the extent to which the intended programme outputs have been achieved over two programming cycles, a selection of outputs has been made. These outputs are: 1. tracking and reporting mechanism to follow up on the implementation of reproductive rights recommendations and obligations established at state and entities level, 2. gender-based violence prevention, protection and response integrated into national sexual and reproductive health programmes, 3. number of civil society initiatives involving men and boys in addressing gender-based violence.

Tracking and reporting mechanism to follow up on the implementation of reproductive rights recommendations and obligations was not established at state and entities level (target 1). The first output has not yet been implemented. Preparatory baseline studies had been conducted in 2015, as reported for 2015. The 2017 COAR indicates that a related RO initiative pertinent to SRHR/SDG indicators was pending. According to this report, “The Universal Periodic Review (UPR) reporting mechanism was abandoned in favour of assisting the state structures in developing an SDG-centric reporting system that also captures data relevant to gender equality and violence prevention.”⁹⁴ According to 2018 COAR, a draft Methodology for Conducting the Public National Inquiry on SRHR and GBV in BiH was finalized.

GBV prevention, protection and response integrated into national sexual and reproductive health programmes (target 2). The second output covers a good part of UNFPA’s reported interventions. Specific and thorough actions have been taken in both entities in BiH in this focus area. They are largely related to production of relevant resource packages for the health care system’s response to GBV and CRSV. This work has been done over the years. From 2013 to 2015, relevant assessments were produced⁹⁵ and this was followed up by development of resource packages for the health sector response

⁹⁴ 2017 Annual Report - Bosnia & Herzegovina (UNFPA, 2018a)

⁹⁵ Survey on Perceptions, Attitudes and Opinions of Medical and Social Services Professionals towards Gender Based Violence and Conflict Related Sexual Violence Issues and Survivors (UNFPA, 2014), Masculinities and Gender-Based Violence against Women in Bosnia and Herzegovina (Alvarez Minte & Gaković Hrasnica, n.d.), Stigma against Survivors of Conflict-Related Sexual Violence in Bosnia and Herzegovina - Research Summary (UNFPA, 2015a)

to GBV/CRSV, containing guidelines and training material for health professionals, with endorsement by entity Ministries of Health. In 2016, Training of Trainers for the health sector's response to GBV was held and the rollout of training started. By the end of 2018, the total of 277 service providers in the health and social sectors received training on the response to GBV/CRSV (47 men and 230 women). The training covered primary health care professionals, but also professionals from mental health centres and social welfare centres. Of the total number trained, seven professionals received training on psychosocial support to perpetrators, while the rest of training was directed at work with victims. Thanks to this technical assistance, the internal health system's protocols for GBV were developed and endorsed by line ministries in FBiH and RS.

By the end of 2018, two comprehensive resource packages have been produced for the response of the health sectors to GBV/CRSV in FBiH and RS. In FBiH, the resource package consists of 12 knowledge and operational products, including a resource package for strengthening health sector's response to GBV, training modules and materials for health sector's response to GBV, psychosocial treatment of GBV and CRSV victims, psychosocial treatment of GBV perpetrators, the role of youth in protection from GBV in general and in crisis, treatment of GBV victims in crisis, and an entity level protocol for provision of support to GBV/CRSV victims (adopted in 15 local communities in Sarajevo and Una Sana Cantons). In RS, the package consists of eight knowledge and operational products, including: 1. A Resource Package for the Response of Providers of Health Services in Republic of Srpska to Gender Based Violence, 2. Strengthening the Response of Providers of Health Services in Republic of Srpska to Gender Based Violence – Training Package, 3. Procedures in the Case of Gender Based Violence in the Public Health Institution Health Center in Banja Luka, 4. A Resource Package for the Response of Providers of Psychosocial Services in Republic of Srpska to Gender Based Violence, , 5. Strengthening the Response of Providers of Psychosocial Services in Republic of Srpska to Gender Based Violence – Training Package, 6. Psychosocial Treatment of Perpetrators of Gender Based Violence in the Family - Training Module, 7. Training of Trainers for Psychosocial Treatment of Perpetrators of Gender Based Domestic Violence - Training Manual, 8. Minimum Standards for Prevention and Response to Gender Based Violence in Emergency Situations-Training Package.. Stakeholders have confirmed the value of these documents, stressing their alignment with global UNFPA documents (which have been adapted to the local context thanks to the help of ministries and professionals) and with the Istanbul Convention. According to some stakeholders, in the area of health sector's response to GBV, these interventions have contributed to the biggest breakthrough in this area in the past 10 years. GBV prevention, protection and response has been integrated into the RS SRH policy. The FBiH SRH Framework Plan does not integrate GBV prevention, protection and response, noting that these interventions have been programmatically integrated into other gender equality policies.

When it comes to implementation of the standards set and operating procedures, an example from Banja Luka is illustrative, where the GBV SOP has been fully and formally integrated into work of the Public Health Institute Health Center in Banja Luka. This is the biggest health care centre in RS, providing health care to more than 200,000 inhabitants. The procedure for treatment of GBV victims was verified by the Quality Department of this institution. It was registered under a specific code and has the same status as all other mandatory procedures in the health centre, while all staff have been familiarized with it. Similarly, the protocol was adopted in the Gorazde Health Care Centre and 15 local communities in FBiH.

The planned number of civil society initiatives involving men and boys in addressing gender-based violence was partly achieved (target 3). Concerning the output related to number of civil society initiatives involving men and boys in addressing GBV, the target for this output from the CPD 2015-2019(2020) is three, compared to the baseline of one. UNFPA has attempted to direct interventions for perpetrators of violence. In this context, training was delivered to representatives of

Mental Health Centres and Social Welfare Centres in Banja Luka for work with perpetrators. Also, a Study of Masculinities and Gender-Based Violence against Women in BiH has been developed over several years of the CP, but has not been published yet. This study was intended to inform further UNFPA and others' work with men and boys. In addition, theatre plays for alleviating stigma against CRSV victims engage boys. Other gender transformative initiatives included support for BiH's Women's Football Team (support to national games, fathers and daughters football match, production of promotional video, all in cooperation with the BiH Football Association), which is another demonstration of innovative approaches to transformation of traditional gender roles.

Three civil society organizations were trained on establishing and working with victims' self-help groups. The capacity of these specific organizations has been considered a lasting resource in assistance to victims of GBV, including CRSV and trafficking in human beings. The three organizations are: Buducnost from Modrica, Udruzene zene from Banja Luka and Izvor from Prijedor.

GE Outputs not planned by the CPD. Other outputs of UNFPA in the area of GE, or rather responses to GBV/CRSV, have been directed at alleviating stigma against victims of CRSV. This work began in 2015 with baseline research on stigmatization of CRSV victims.⁹⁶ Stigma alleviation has been approached by the UNFPA CO from at least three different angles - youth theatre plays, work with the Inter-religious Council (IRC), and work in selected municipalities on implementation of a stigma alleviation programme. Theatre plays have been staged in 12 locations across BiH by the end of 2018. Stigma alleviation activities have been piloted in 12 local communities. Apart from this, a promotional video was produced. Breakthrough results have been achieved in work with the IRC, as a Declaration on Denouncing stigma against CRSV survivors was prepared, publicly signed and announced in 2017. Cooperation with IRC continued into 2018 and a joint Manual of the Inter-religious Council in Bosnia and Herzegovina for members of the clergy working with survivors of conflict related sexual violence was produced and promoted.⁹⁷ This was the first intervention of this kind in the world, as reported by stakeholders. The manual was created by psychotherapists and theologians together, and it looks at treatment of CRSV victims from both of these perspectives. As a result of work with IRC and local communities, it was reported that clergy of all four faiths started engaging in local dialogue to prevent stigmatization of CRSV victims and ensure referral to relevant services. According to some stakeholders, the work on stigma alleviation has also encouraged initiatives for reparation of damage. On top of this, as a result of the UNFPA CP, the total of 15 media professionals received training on contextualized reporting on CRSV and guidelines on reporting on CRSV. There is no evidence on follow up on these activities and measurement of their effects.

Progress toward outcome - Mainstreaming of provisions to advance gender equality

Mainstreaming of provisions to advance gender equality has been achieved to a good extent. The UNFPA CP over the two programme cycles has generally focused on one aspect of advancing gender equality, which is prevention of and response to GBV, together with individual gender transformative initiatives. When it comes to integration of GBV prevention, protection and response into national sexual and reproductive health programmes, the evidence of related outputs contributing to achievement of the overall outcome for gender equality can be found in the results achieved relating to development of resource packages (containing knowledge and operational products outlined above under outputs) for health sector's response to GBV/CRSV. More specifically, with the endorsement of these packages by line ministries, delivery of training of trainers and the rollout of training, as well as implementation of protocols for treatment of GBV and CRSV victims, generally and in crisis, it can be concluded that gender equality provisions have been mainstreamed into the health system to a large extent. This is further evidenced through stakeholders' views that this work has contributed to the biggest breakthrough in this specific field of intervention over the past several years. It should be noted that the health sector's response to GBV has already been mainstreamed as an obligation stemming from

⁹⁶ (UNFPA, 2015a)

⁹⁷ A Joint Manual of the Inter-Religious Council in Bosnia and Herzegovina for members of the clergy working with survivors of conflict-related sexual violence (UNFPA, 2018b)

policies relating to GBV in BiH, most notably through the Laws on Protection from Domestic Violence in RS and FBiH, relevant bylaws stemming from this legislation (including rulebooks on treatment of perpetrators), but also Strategies for prevention and combatting domestic violence in FBiH and RS and the Framework Strategy for Implementation of Istanbul Convention. UNFPA’s work has contributed to the mainstreaming of these provisions by providing practical instruments for implementation in practice. The effects of their implementation in practice yet remain to be measured.

When it comes to mainstreaming of gender equality provisions through other UNFPA initiatives in the field of GBV and GE in general, evidence of mainstreaming of stigma alleviation can be found in IRC’s Declaration on Denouncing stigma against CRSV survivors. However, other UNFPA supported activities related to stigma alleviation have not resulted in mainstreaming of provisions to advance gender equality, but were rather localized initiatives without formalization of rules and their integration into institutional and legal systems. These activities have generally focused on raising of awareness and changes of attitudes towards victims, e.g. theatre plays in 12 local communities.

If the CPD 2015-2019(2020) outcome for GE is considered “Advanced gender equality, women’s and girls’ empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth” and the accompanying outcome indicator “Proportion of the Universal Periodical Review accepted recommendations on reproductive rights from the previous reporting cycle implemented or action taken”, it is concluded that this outcome cannot be measured by this specific indicator. This is because the UNFPA CP replaced this activity by initiating an SRHR inquiry. However, it could be argued, based on the review of outputs delivered, that mechanisms for a better response of the health sector to GBV/CRSV have been established and integrated in the health system. Stakeholders said that a good number of medical professionals now have clear guidance on how to recognize and work with victims of GBV/CRSV. However, problems are still reported in terms of formal identification of a low number of GBV/CRSV victims by the health system either as result of persistent lack of understanding of medical professionals or as a result of stigma. Awareness has been raised on methods to alleviate stigmatization of CRSV and GBV victims in order to ensure their better access to rights and services, and stakeholders and reports from the field have confirmed greater openness of clergy to contribute to stigma alleviation. A total of 51 municipalities in BiH have been covered by interventions within this programme area. There is no data, however, on how many victims were reached or assisted as result of the UNFPA CP.

Although UNFPA is a partner on the Joint Programme on GBV/CRSV with three other agencies, UNFPA has been the sole assistance provider in the areas of health sector’s response to GBV/CRSV and alleviating stigmatization. For this reason, the majority of progress on intended outputs can be attributed to UNFPA CP.

4.3.3. Efficiency

<p>Evaluation question</p> <p>EQ6.To what extent has UNFPA made good use of its human, financial and technical resources, and has used an appropriate combination of tools and approaches to pursue the achievement of the results defined in the UNFPA programme documents?</p>
<p>Summary findings</p> <p>Funding for this component has been unstable, varying depending on donor funds. The number of staff is higher in relation to other components. UNFPA demonstrates financial discipline under this component. Together with several implementing partners (with specific GBV expertise, and those providing operational support), they have delivered a considerable number of activities. Delivery of some outputs has been extended over several years. Internationally recognized methodologies have been used in GBV response, and innovative approaches to stigma alleviation and gender transformative actions.</p>

GE component financing unstable, delivery of some GE results not time efficient. The analysis of funds spent on selected activities in this programme area for the period 2013-2018 found that around 600,000 USD was spent on these activities, excluding the costs of UNFPA GE staff and other costs. The allocated percentage of the total yearly budgets for interventions in this programme area has ranged from 12 to 28 per cent of the overall budget. In 2014, the lowest 12 per cent was allocated, which stands out in relation to all other years, when on average 26 per cent of the budget was allocated to this component. This difference could be attributed to lack of donor funds in 2014. There is no full consistency in the planning of budgets from year to year, with the budgets decreasing or increasing by roughly 100,000 to 150,000 USD between years. The execution of budgets has ranged from 87 to 100 per cent. This is also a result of the UK FCO's financial year spanning 1 April to 31 March and occasionally late payment of funds with expectations that 90 per cent of the budget be spent by 31 December.

Table 15 Gender equality component budget allocation and expenditure

	2013	2014	2015	2016	2017	2018	Total
Allocated total	251,194	167,378	324,750	276,930	238,033	318,202	1,576,487
Spending total	218,787	167,928	327,128	263,474	219,697	190,028	1,387,043
Spending on activities	10,386	90,977	191,354	91,065	120,944	95,571	600,296

The biggest amounts were spent on health sector's response to GBV, followed by stigma alleviation activities, gender transformative actions, and other outputs. This reflects the difference in funding allocated by donors and the core UNFPA budget. The activities related to health and stigma were funded as part of the UK FCO-funded Joint Programme.

Table 16 Gender equality component expenditure by project

	2013	2014	2015	2016	2017	2018	Total (2013-2018) in USD
Health care response to GBV		27,329	97,864	67,035	40,002	26,882	259,111
Stigma alleviation					68,168	63,906	132,074
Gender transformative actions			53,528	24,030	3,227		80,785
Developing strategies	10,385	63,648					74,033
Victim's self-help			39,963		9,546	4,783	54,292
Total activities	10,384	90,977	191,354	91,065	120,944	95,571	600,296
Staff costs	80,307	67,388	64,246	58,347	49,080	63,607	382,976

The financial information suggests that this area of UNFPA CP has been the most resourced, as a result of external donor funding (UN Action Against Sexual Violence in Conflict and UK FCO). Given the number and reach of activities, it can be argued that the activities were generally contributing to achieving the desired outcomes. However, the COARs and financial reports indicate that UNFPA was struggling to bring delivery of activities to a successful finalization over several years. For example, the work on health sector's response to GBV, as embodied in production of the resource package and delivery of training, has extended over five years, taking half of the budget spent on the selected direct activities. The results match the funds invested, but the time invested shows slow progress. Also, significant funds have been invested in the Masculinity Study, while its effects have not materialized. Stigma alleviation spending is the second biggest in this component, and this deliverable has been very visible and praised by stakeholders, although the effects are yet to be measured. A considerable number of activities have been implemented as part of stigma alleviation work, which could pose risks in relation to ensuring focus and lasting effects.

Staff turnover and wide coverage of activities. Over the period 2013-2018, the GE component in UNFPA CO has experienced continuous changes of staff, but retained institutional memory. Apart from four members of staff working on this component, largely on account of the CRSV JP, the Assistant Representative has been partly working on this component as manager of the gender portfolio (which also includes emergency response). The number of activities is high, reaching 12 in one year of the CP, 2016, and assuming a number of sub-activities. UNFPA has worked with several partners in delivery of activities, mostly from the civil society sector, including PPH (Partnership for Public Health), IRC (Inter-religious Council), and several NGOs with proven reputation in work with victims of violence and perpetrators. When it comes to specific expertise for GBV and CRSV, UNFPA BiH was assessed as having sufficient expertise, particularly having in mind close relationships with relevant professionals from BiH's public sector who were engaged in delivery of activities.

From the annual reports and interviews with stakeholders, it is clear that UNFPA has been using global and international documents and tools, adjusting them to the BiH context to localize standards for health sector's response to GBV. There is evidence of this in the development of the resource package for response to GBV in general, and in crisis situations. Also, UNFPA has been innovative in activities related to stigma alleviation and gender transformative actions. This is demonstrated by the theatre plays for reducing stigma against CRSV victims, work with IRC as until then a non-traditional partner, and by supporting BiH's Woman's Football Club. The latter resulted in greater visibility of women's football in BiH, by attracting new fans, as well as development of the Football Team's capacities to promote women's football, seek funds and get equality of treatment of women football players, thus breaking away from traditional gender norms.

4.3.4. Sustainability

Evaluation questions
EQ7 Are programme results sustainable in short and long-term perspectives? NB: 3 years or less = short term. More than 3 years = long term.
EQ8 To what extent have the partnerships established by UNFPA promoted the national ownership and sustainability of supported interventions, programmes and policies?
Summary findings
Endorsement of the resource package for health sector's response to GBV/CRSV by health authorities indicates good prospects of short and long-term sustainability, as well as the training of health care providers. Formal partnerships have not been signed, but GBV response is mandated under domestic legislation and policies for combating GBV and protecting victims of GBV/CRSV. Not all stigma alleviation initiatives and gender transformative actions show results of sustainability. Possible exceptions are interventions in cooperation with the Women's Football Team and the Interreligious Council.

Some interventions in this programme area have potential of being sustainable in the short term and long term. This is because either policies or procedures were developed and endorsed and training was delivered (e.g. the resource package for health sector's response to GBV). Other interventions show poorer prospects for sustainability as they introduced practices that require further support to become mainstreamed into institutional and legal systems and have lasting effects (e.g. stigma alleviation activities).

When it comes to work related to health sector's response to GBV, the fact that the resource packages were created in close cooperation with line ministries, that training of trainers was delivered and a group of trainers secured as a lasting resource in the form of local professionals, and the fact that training was delivered to a large number of professionals, all these factors contribute to the likelihood of

sustainability of these actions. Stakeholders have confirmed ownership of these interventions by relevant ministries. On top of this, sustainability is guaranteed by the already existing policy framework in RS and FBiH pertaining to treatment of victims and perpetrators (laws, bylaws, strategies, international obligations).⁹⁸ Operating procedures for work with GBV victims have been formalized and embedded into the regular practice of several medical centres, with potential for replication. The health authorities have replication plans, but they report that further efforts need to be invested to embed the operating procedures to become part of everyday work of every relevant health institution in the country. Furthermore, although a group of trainers exists in both entities, it is not certain that budgets will be approved for further training of medical professionals on health sector's response to GBV/CRSV. It was already noted above that even in places where the operating procedures have been embedded, there is very low identification of GBV victims, which is not comparable with the current violence prevalence numbers. Apart from replication and further regulation of new practices, regular monitoring and evaluation of their implementation needs to be ensured.

Concerning activities related to stigma alleviation, it was found that activities at the local level have largely been isolated and not embedded into policy and practices of local institutions. However, UNFPA and the BiH Ministry of Human Rights and Refugees have adopted a joint guideline for stigma alleviation, in the form of Stigma Alleviation Program.⁹⁹ The document outlines deliveries and proposed interventions for a whole array of services. Another exception is the IRC's Declaration on Denouncing stigma against CRSV survivors and the manual produced for religious officials. However, stakeholders said that without follow up work with religious officials, the manual cannot guarantee sustainability.

Gender transformative actions in the form of the Masculinity Study, for example, will not be sustainable unless these actions are followed up. The work with the BiH Women's Football Team, on the other hand, shows prospects of sustainability in terms of promotion of women's football and women's right to choose, women's health, and gender equality in general. The Football Association has hired one more person to work with the team and promote its status both within the Football Association and wider. It is uncertain, however, to what extent this can be attributed to UNFPA's interventions only or to UEFA's gender policies, but capacities of the Team have increased and are likely to be further utilized for advancing gender equality.

UNFPA has not signed formal partnership agreements with authorities in BiH, but all planning has been done in cooperation with authorities. The FBiH Ministry of Health and the RS Ministry of Health and Social Welfare take full ownership of resources developed as part of interventions related to health sector's response to GBV. Other institutions and organizations have been recognized as partners in UNFPA's Partnership Plans, including religious institutions and the BiH Women's Football Team.

4.4. Population dynamics

4.4.1. Relevance

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

⁹⁸ Although these apply to victims of domestic violence only. (Zakon o zaštiti od nasilja u porodici FBiH, 2013), (Zakon o zaštiti od nasilja u porodici Republike Srpske, 2015), the Istanbul Convention (Istanbulska konvencija stupa na snagu, 2014), etc.

⁹⁹ *Konferencija Ministarstva i UNFPA: Borba protiv stigmatizacije žrtava seksualnog nasilja* (Vijeće ministara Bosne i Hercegovina, 2017)

Summary findings

Under this component, the UNFPA programme has been adapted to the needs of older persons and migrants. The programme has been largely in line with international policy frameworks, UNFPA strategic plans, and the UNDAF. The CPDs make reference to domestic development strategies, but delivery is generally informed by consultation with stakeholders. UNFPA successfully responded to the 2014 floods by delivering activities targeting older persons.

There is evidence that the UNFPA Population Dynamics activities have been adapted to a good extent to different needs of different groups of population, including marginalized and vulnerable populations, most notably older persons. The CPDs 2010-2014 and 2015-2019(2020) analyse and take into account the position of different categories of the BiH population with a view to plan support for development of population policies in BiH. The CPD 2010-2014 was developed prior to release of 2013 census data, but relies on the Labour Force Survey and other statistical sources to demonstrate that there has been substantial internal and external migration, that the fertility rate is low and that the country has an ageing population. This CPD also notes that social exclusion is a problem and defines vulnerable groups (the older persons, people with disabilities, displaced persons, unemployed people, migrants and minorities, including Roma). The CPD 2015-2019(2020) uses the preliminary 2013 census data, noting a decreased population, as well as negative population growth due to declining birth rates, increasing mortality rates and continued migration. This CPD indicates that relevant population policies are not in place, including the policies for youth and older persons. For these reasons, the planned outputs under PD component in CPD 2010-2014 focus on socially excluded (including older persons) and migrant populations (youth targeted under the Youth Employability and Retention Programme - YERP implemented in the period 2009-2013 in cooperation with UNDP, UNICEF, UNV and IOM). The focus on older persons as a target group is upheld in the CPD 2015-2019(2020), along with a continued focus on building governmental capacities to create evidence-based population policies based on emerging population issues (low fertility, ageing and migration). The analysis in CPDs is supported by the 2013 CCA, which notes “At the State level, there are no coherent policies to address the low fertility rate, ageing and migration. Some family friendly policies are in place in the RS, as a reaction to negative population growth starting in 2002, while the FBiH has not developed such policies as of the date of the publication of this report, despite its entering of the stages of negative population growth in 2010.”¹⁰⁰ Also, CCA noted that a “Comprehensive migration database and evidence-based policies are lacking at State and Entity levels”. For this reason, the CCA recommends “The collective UN efforts should also provide assistance in facilitating development and implementation of evidence-based population policies in line with demographic trends, with full respect for gender and human rights, and integrated in the broader development process”. This finding is confirmed in UNFPA programming in BiH.

There is evidence in AWP, COARs and from stakeholder interviews that the CP has focused on two target groups under the PD component over the years: migrants and older persons. The focus on migrants has been placed as part of implementation of the YERP and establishment of migration database with the BiH Ministry of Security, and this work features in the CP in 2013 and 2014 of the evaluation period. The focus on older persons has been continuous throughout two CPs. Even though the UNFPA supported work related to migration had stopped after 2014, stakeholders have confirmed a continued need for an evidence base in the area of migration for development of sound policies. Monitoring of migration has also been an explicit prerequisite for BiH’s rapprochement with the EU in the accession process. It was observed through stakeholder interviews that, although YERP had been a project targeting youth specifically, UNFPA’s activities on establishment of migration database in the BiH Ministry of Security were comprehensive and intended to build monitoring systems for all migrants. Stakeholders have also confirmed the importance of working on issues of older persons, as very little, or no attention has been paid to this group of the population through domestic or international initiatives. The status and needs of older persons have been identified as part of the work on Strategies for Improving the Status of Older Persons in FBiH and RS, but also earlier, in 2013 and 2014 while

¹⁰⁰ *Common Country Assessment Bosnia and Herzegovina 2013* (United Nations Country Team, 2013)

UNFPA was developing a National Social Policy on Older Persons with the BiH Ministry of Human Rights and Refugees. It is not clear to what extent the planning of work in relation to older persons under CP was informed by the Ombudsman's report on the state of human rights of older persons¹⁰¹ but this document does identify a lack of strategic approach to the status and needs of older persons and the interviewed institutions from both entities stress the need for adoption of relevant strategies.

UNFPA programme is mostly aligned with international and national policy frameworks and has been able to adapt to changing local context. UNFPA CPDs for BiH reflect clearly the UNFPA's global strategic goal in relation to population dynamics and the need for creating evidence-based population policies.¹⁰² This is defined in the CPD 2010-2014 outcome for this component "The Government, at all levels, is able to base policies on a quantitative and qualitative analysis of disaggregated data, policy assessments and reviews, with attention focused on socially excluded groups and migrant populations" and in CPD 2015-2019(2020) "Strengthened national policies and international development agenda through integration of evidence-based analysis of population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality." The UNFPA Strategic Plans provide further guidance on how population dynamics should be monitored and used as evidence base, that is, by taking into account "the growth or decline of a population from high or low fertility, shifts in age structures, urbanization, and migration" (2014-2017), and also by shifting focus from historical data production from censuses, surveys and other similar statistical sources to "non-traditional data in order to fill gaps" (2018-2021). Both programme cycles of UNFPA in BiH have demonstrated efforts to integrate these strategic priorities in its interventions. These activities include the improvement of migration statistics, conducting of a survey of the prevalence of violence against women, supporting the census activities (the latter two prior the evaluation period), collecting and analysis of census data for advocacy, mobilization for localization of SDGs, mobilization for MICS6 and DHS, as well as activities to ensure a population situation analysis.

Concerning application of human rights approach to CP design and implementation, both CPDs draw attention to marginalized groups in the area of PD. For example, the CPD 2010-2014 identifies social exclusion as a problem and vulnerable groups, including elderly, people with disabilities, displaced persons, unemployed people, migrants and minorities, including Roma. However, the PD component, according to the 2010-2014 CPD, targets migrants and socially excluded, including the older persons. In the CPD 2015-2019(2020), the proposed programme claims applying a human rights-based approach in all interventions, but with specific vision to "strengthen partnerships for the development of comprehensive rights-based and evidence-based population policies".

The CPDs do not make specific reference to gender mainstreaming, although the work on data collection and analysis for evidence-based population policies include indicators for women and men. There is evidence of accounting for different implications of ageing for women and men in the Strategies for Improvement of Status of Older Persons.

The UNFPA CPDs do not quote the ICPD goals but they are reflected in the CP. In the area of PD, the interventions are clearly in line with the ICPD objectives related to Interrelationships between population, sustained economic growth and sustainable development, Population growth and structure (specifically in relation to fertility, mortality and population growth rates and older people), and International migrations.¹⁰³ The SDGs were not adopted

As part of South-South cooperation, UNFPA facilitated cooperation between its implementing partner Partnership for Public Health and the Ministry of Labour and Social Protection of North Macedonia through a capacity building event where positive practices and experiences from BiH were conveyed to counterparts in North Macedonia on establishment and management of a network of Health Ageing Centres. As a result, it was reported that the Government of North Macedonia was going to support opening of at least two such Centres.

¹⁰¹ *Specijalni izvještaj o stanju ljudskih prava starih osoba* (The Institution of Human Rights Ombudsman of Bosnia and Herzegovina, 2010)

¹⁰² These interventions correlate to Outcome 4, Outputs 1, 2, 3 and 4 from the Strategic Plan 2014-2017 and Outcome 4, Outputs 1 and 2 from the Strategic plan 2018-2021.

¹⁰³ *Programme of action* (United Nations Population Fund, 2004)

at the time of CPD drafting and approval. However, some UNFPA interventions in PD are pertinent to SDGs (please see Table 9 Overview of SDGs and targets relevant for UNFPA CP).

UNFPA CP in the area of PD has been aligned with UNDAF 2010-2014 and UNDAF 2015-2019(2020) in their components related to Democratic Governance and Social Inclusion (evidence-based policies and work with older persons, respectively).

In the CPD 2010-2014, several national priorities are quoted as relevant to this area of intervention: the national development strategy, social inclusion strategies, and the European Partnership and European Union Integration Strategy. National policies are not quoted in CPD 2015-2019(2020). Documentary search and stakeholder interviews have confirmed that BiH does not currently have population policies, while development policies do exist.¹⁰⁴

One part of the CP, related to work on Strategies for Improvement of Status of Older Persons and support to Healthy Ageing Centres, does not seem to reflect the UNFPA Strategic Plans, including the current one for 2018-2021. Older persons are not featured as a target group in these plans, but the CPDs have planned outputs related to implementation of the Madrid International Plan of Action on Ageing. The CP interventions in this area reflect alignment with this international policy framework. Despite elaborate legislation on health and social protection in individual jurisdictions in BiH, older persons do not feature as a specific target group in any policy. For this reason, the drafting of Strategies for Improvement of Status of Older Persons in the two entities has been considered by all stakeholders as a very relevant intervention and in line with the domestic context.

4.4.2. Effectiveness

Evaluation questions
EQ3. To what extent have the intended programme outputs been achieved? To what extent did the outputs contribute to the achievement of these planned outcomes: developing of evidence-based national population policies, and what was the degree of achievement of the outcomes?
EQ 4 To what extent has UNFPA contributed to an improved emergency preparedness in BiH, and in the area of maternal health / sexual and reproductive health including MISP?
EQ5 To what extent has each office been able to respond to emergency situations in its Area of Responsibility (AoR), if one was declared? What was the quality and timeliness of the response?

Summary findings
UNFPA has met the targets related to strategies for care of older persons, and partly met the targets related to population policy making. It is unknown to what extent the target related to number of government and civil society professionals trained in collecting, processing and interpreting migration data has been met. The unintended, but delivered outputs are related to establishment of Healthy Ageing Centres. Development of migration statistics, strategies for older persons, SRH and youth strategies has contributed to development of evidence-based national population policies. Improved emergency preparedness has not been addressed under this component. However, UNFPA's emergency response during 2014 floods included establishment of two Healthy Ageing Centres in flooded areas.

Achievement of outputs

Three key outputs were selected for the evaluation of effectiveness of the UNFPA CP under PD: 1. Government and statistical agencies have increased knowledge and skills to establish a migration

¹⁰⁴ For example, the Strategic Framework for BiH from 2015 *Strateški okvir za BiH* (Directorate for Economic Planning, 2015) does examine the status of population and population dynamics under the Chapters Reducing Poverty and Social Exclusion, and Improving Health Care, and identifies a set of measures under the following priorities: To improve the system for protection of human rights and development of BiH relations with diaspora, Efficient coordination in social protection and pension areas, and Improving coordination in the health sector.

surveillance system and to integrate it into the development and implementation of strategies and policies, 2. Officials of the Directorate for Economic Planning have the knowledge and skills to implement the Madrid International Plan of Action on Ageing through the European regional implementation strategy and through strategies for older persons, and 3. Strengthened institutional capacity for the formulation and implementation of rights-based policies that integrate evidence on emerging population issues (low fertility, ageing and migration) and their links to sustainable development.

Public administration and civil society professionals were partly trained in collecting, processing and interpreting migration data disaggregated by sex and age (target 1). It was reported in 2013 that an overall migration statistics methodology was developed in cooperation with the BiH Statistical Agency, thus increasing its capacities through technical assistance. At the same time, work was done with the BiH Ministry of Security for the establishment of a migration database, which was reported as completed in 2014. UNFPA supported the procurement of the hardware and software for this effort. This intervention was delivered in line with Eurostat requirements for monitoring of migrations, as per EU requirements from BiH on its path toward accession to the EU. According to stakeholders, however, these resources have not been put to efficient use, as the technical and methodological solutions were not integrated into the BiH Ministry of Security's Migration Information System and the BiH Agency for Statistics could not access the migration data. The stakeholders have confirmed continued relevance of this activity and the need for monitoring of external migrations, integration of the two statistical systems, and efficient reporting to Eurostat. The promising news is that the BiH Ministry of Security is working on reengineering its Migration Information System and is planning to integrate the results previously achieved under YERP (by UNFPA). The aim is to ensure sufficient business intelligence that will enable an exchange of statistical information with the BiH Agency for Statistics. It is not clear how many governmental and civil society professionals were trained in collecting, processing and interpreting migration data disaggregated by sex and age. However, the migration database was established, although it has not been put in use effectively so far.

Parliamentary Assembly adopted the Madrid International Plan of Action on Ageing (MIPAA) (target 2). BiH is a signatory of MIPAA. Although not defined as part of this target, the work on Strategies for Improving the Status of Older Persons in RS and FBiH was carried out. The two strategies were drafted in cooperation with entity authorities and civil society. The RS Strategy is on the agenda of the RS People's Assembly awaiting debate, while the FBiH Strategy adoption has been stalled by general election and the slow formation of government in FBiH. Both strategies are elaborate documents, drafted by local professionals, containing needs assessments based on the available statistical data, identification of strategic priorities, operationalization and monitoring and evaluation plans. Both strategies have been created through a wide consultative process with interested stakeholders and UNFPA has greatly assisted this process.

When it comes to establishment of and support for Healthy Ageing Centres, it should be noted that this output has not been specifically foreseen by the CPDs, although this activity could be linked with one of the SRHR outputs planned under CPD 2010-2014 "Local government and social-sector institutions in selected municipalities adopt standard methodologies to plan, implement and monitor local action plans for older persons, and to ensure their participation". However, good practice in Sarajevo was observed, and in line with expressed needs, the rights-based approach, and the ICPD agenda for older persons, UNFPA decided to support these centres. During the floods in 2014, two Health Ageing Centres were established in Modrica and Samac-Domaljevac, with the help of the first Healthy Ageing Centre in Sarajevo. This was evidence of replication of good practice and knowledge exchange. The UNFPA supported Survey of Effects of Centres for Healthy Ageing on Older Persons¹⁰⁵ has been used for advocacy of opening of such centres in local communities, according to 2015 and 2016 reports. The process of opening Healthy Ageing Centres has continued, expanding to Tuzla and Banja Luka. Today in BiH, Healthy Ageing Centres are operational in eight cities/towns, although not all to a full standard.

¹⁰⁵ Survey of Effects of Centres for Healthy Ageing on Older Persons (Ramić-Čatak, Stoisavljević, Šabanović, Knežević, & Bašić-Čatić, 2016)

The users of Healthy Ageing Centre in Sarajevo were interviewed (this centre has become the educational centre and knowledge hub for all healthy ageing centres). Their testimonies indicated great satisfaction with the work of this centre and support for the dignity of the “third age”. While listing all the activities that they had at their disposal in the centre, and making proposals for additional services (mostly medical and artistic), the users highlighted that the centre added value to their lives, health and general well being. They supported further replication of the Health Ageing Centre’s practice and said that they participated in replication by visiting newly established centres and sharing their experiences.

Policies have been developed at state and entities level using secondary analysis of census data, but a Population situation analysis has not yet been conducted to identify priorities and formulate policies and programmes (target 3). It was expected that three policies would be developed in relation to the baseline of zero. Links with other components of UNFPA CP and deliverables should be noted in this context. Namely, apart from results in developing Strategies for Improvement of Status of Older Persons, the work on youth and SRH strategies evaluated in the sections above directly relate to the achievement of this output, although not placed under the same PD component of UNFPA CP. This separation may seem logical, given different portfolios within the CO, but the linkages between these deliverables are evident. According to reports and stakeholders, there has been continuous advocacy for the development of an evidence-based population policy. However, comprehensive population policies have not been developed at any level of authority in BiH. Still, there have been efforts on the part of UNFPA to develop youth, SRH, and strategies for older persons, constituting segments of a comprehensive population policy. UNFPA has promoted the ICPD agenda (COAR 2013) as well as SDGs among its stakeholders. According to COAR 2016, CO has continuously advocated with the UNCT, institutional and development partners for development of SDG monitoring and reporting framework, within a wider process of SDG localisation in the country. This was confirmed by stakeholders interviewed, who stressed the need for support in localization of SDGs and support for statistical institutions. However, it was also noted by stakeholders that the institutional capacities were too weak to absorb assistance and undertake the challenging job related to measuring of achievement towards SDGs. Generally, in the area of development of evidence-based population policies, stakeholders have reported rather scattered work of UNFPA since the preparation for census. Namely, data production and collection is costly for both UNFPA and local institutions, which means that up to date data relevant for population policies can hardly be gathered. The MICS has not been carried out for several years, while a DHS has not been conducted ever. UNFPA has been advocating for better data collection and processing in BiH, but has not had the resources to contribute with direct data production, in line with the UNFPA strategic plans, since the Violence Prevalence Survey. It is promising, however, that UNFPA has already commissioned the Population Situation Analysis, and is planning to build capacities on Population Projections, in cooperation with statistical institutions in BiH in 2019. Stakeholders have welcomed these as very valuable and needed deliverables. By producing the Population Situation Analysis, the relevant output indicator from CPD 2015-2019 will have been achieved.

Progress toward outcome - Development of evidence-based national population policies

The development of evidence-based national population policies has been achieved to a good extent. Given the delivery of outputs evaluated above, it can be concluded that the outcomes have been partly achieved. The work on migration database has not yielded results yet, but stakeholders have confirmed that there is potential to revitalize the deliverables from years before and ensure good quality data on migration and its exchange with relevant institutions. When it comes to socially excluded groups, policies have been developed for older persons, based on the available data, but have not been adopted yet. A youth policy is in place in RS, but not in FBiH. FBiH has an SRH strategy (due to expire within a year) and RS is in the process of adopting one. It cannot be concluded that these policies have been based on fully relevant data as it is known that a reliable mechanism for collection of data on SRHR has not been established in the country.

When it comes to the wider ICPD and SDG agendas, the country and its entities are still at the initial stages of localization of these standards and targets. UNFPA is expected to contribute to the creation of an evidence base through the Population Situation Analysis and Population Projections, and it has advocated conducting of other surveys, e.g. MICS and DHS, but this has not materialized.

UNFPA has been the sole assistance provider among donor and development agencies in the areas of support for older persons. When it comes to work on the migration database, this work had been done under the YERP project, which involved other UN agencies. The promotion of SDGs has been done alongside other UN agencies, primarily the UN Resident Coordinator, while the advocacy for MICS has been done together with UNICEF.

4.4.3. Efficiency

Evaluation question
EQ6.To what extent has UNFPA made good use of its human, financial and technical resources, and has used an appropriate combination of tools and approaches to pursue the achievement of the results defined in the UNFPA programme documents?

Summary findings
This component is underfinanced in relation to needs for data collection and its use in evidence based policy making, and in relation to SRHR and GE components. UNFPA demonstrates financial discipline under this component. One member of programmatic staff has been assigned to diverse, yet related duties. A relevant implementing partner has been selected for implementation of activities related to addressing the issues of older persons.

The Population Dynamics component is underfinanced in relation to needs for data collection and its use in evidence based policy making. Analysis of the funds spent on selected activities in this programme area for the period 2013-2018 found that around 235,000 USD was spent on selected PD activities, excluding the costs of UNFPA staff and other costs. The allocated percentage of the total yearly budgets for interventions in this programme area has ranged from 6 to 18 per cent of the overall budget, but on average of 10 per cent. The budget utilization rate has been around 100 per cent for this component of the programme. There is evidence of consistency in the planning of budgets for specific interventions and expenditures, which demonstrates budgetary discipline, according to annual financial reports.

Table 17 Population dynamics component budget allocation and expenditure

	2013	2014	2015	2016	2017	2018	Total
Allocated total	108,372	249,241	115,631	105,232	107,218	145,023	830,718
Spending total	108,263	245,080	110,549	101,101	107,023	144,564	816,580
Spending on activities	3,833	135,343	40,454	20,297	17,171	17,693	234,791

The biggest amounts were spent on the healthy ageing centres, followed by data processing and policy development, and the migration database.

Table 18 Population dynamics expenditure by activity

	2013	2014	2015	2016	2017	2018	Total (2013-2018) in USD
Healthy ageing centres		102,636	28,860	16,460	14,858	4,255	167,070
Policies, data processing	3,833	3,148	11,594	3,837	2,313	13,438	38,163
Migration database		29,558					29,558
Total activities	3,833	135,343	40,454	20,297	17,171	17,693	234,791
Staff costs	97,462	99,000	66,162	66,758	86,607	95,448	511,437

The financial information suggests that this component of CP has had the smallest budgets, which prevented the CO in engaging in more ambitious data collection activities and capacity building for evidence-based development of population policies. More specifically, during the period under evaluation, the CO has not been able to deliver a single survey or other reliable data collection effort on any of the pertinent issues. Some activities are planned for 2019, including the Population Situation Analysis and the Population Projections, which is promising. The absorption capacities of partner institutions, i.e. the statistical agencies, are a constraining factor, which has made CO's advocacy activities less effective.

Instead, the funds available have been used for interventions that have not been prioritized by CPDs (e.g. the Healthy Ageing Centres). The relevance of these Healthy Ageing Centres has been proven in terms of direct needs and advocacy efforts around demographic challenges in the country, and it could be argued that the spending was not inefficient or excessive. Given the general lack of funds for this component, opting for interventions that are less costly (in relation to data collection), yet relevant and beneficial activities seems plausible.

One PD staff person is assigned to diverse, yet related duties; relevant implementing partner.

Over the period 2013-2018, the PD component in UNFPA CO also experienced changes of staff, but with a smooth transition. One technical staff person is in charge of this programme area, but this member of staff is also in charge of monitoring and evaluation for the CP. By the nature of his job, this member of staff has been involved in the work of other components too, particularly in the areas of policy drafting and development of the results frameworks. However, this component of the CP has focused on the work related to older persons, according to COARs and financial reports, while very little resources have been allocated for data collection, for advocacy of provision of sound and reliable data by relevant authorities in BiH, and for development of evidence-based population policies, all of which feature predominantly in UNFPA strategic plans and CPDs. There is evidence in the Resource Mobilization Plans (for the years 2016, 2017, 2018) of efforts to raise funds for several surveys, including the Population Situation Analysis, Population Projections, MICS6 and DHS.

The CO in BiH has been delivering activities through an implementing partner - Partnership for Public Health (PPH), which has been involved largely in establishment and development of Centres for Healthy Ageing. This partner has demonstrated relevant capacities and expertise for this work, given its know-how and long standing experience in managing the Healthy Ageing Centres.

4.4.4. Sustainability

Evaluation questions
EQ7 Are programme results sustainable in short and long-term perspectives? NB: 3 years or less = short term. More than 3 years = long term.
EQ8 To what extent have the partnerships established by UNFPA promoted the national ownership and sustainability of supported interventions, programmes and policies?

Summary findings

Development of policies for older persons, youth and SRH shows good prospects of sustainability, if policies are adopted, budgets are allocated, and both are continuously monitored. Methodologies for population situation analysis and population projections can be transferred to domestic institutions for regular use. Local ownership of Healthy Ageing Centres could guarantee their sustainability. Formal partnerships have not been signed.

Some interventions in this programme area have potential of being sustainable in the short term and long term. The Strategies for Improving the Status of Older Persons, when adopted by relevant authorities, could provide policy guidance on this issue for the next 10 years. However, their implementation will depend on the willingness and ability of domestic authorities to allocate sufficient resources for implementation, as the strategic documents themselves do not contain the costing elements. When it comes to Health Ageing Centres, they have demonstrated prospects of sustainability by the fact that local authorities have allocated funds for their operations and maintenance, e.g. in Sarajevo, Modrica and Banja Luka. There seems to be ownership of local authorities over these centres and clients have testified about their contributions in order to support the work of these centres. At the same time, they stressed the need for renovation of older centres and continuous improvements.

When it comes to results related to the migration database, from 2013, although this activity was considered suspended and without effective results in the evaluation period, there is an indication that the BiH Ministry of Security will revitalize the results and will integrate the strategy for migration monitoring in line with Eurostat rules in its regular processes and exchange with the BiH Agency for Statistics. This is part of the process of reengineering the BiH Ministry of Security's Migration Information System, which indicates good sustainability prospects.

The UNFPA CO's work on evidence-based population policies, collection of relevant data and advocacy of these efforts in BiH has not been substantial enough to provide for sustainability. The constraining factors included lack of funds and absorption capacities of relevant institutions in BiH. It should be noted that the authorities in BiH have not so far engaged in development of comprehensive population policies in individual parts of the country. More efforts need to be invested in raising of awareness, defining a policy framework for population development and development in general, and integration of existing policies (youth, SRH, older persons policies) into a future population policy framework.

UNFPA has not signed formal partnership agreements with authorities in BiH. However, the Partnership Plans in the PD component outline the key partners, which include governmental and non-governmental organizations. These partnerships have been observed and confirmed during this evaluation.

4.5. UNCT Cooperation and Value Added

Evaluation questions

EQ9 To what extent did UNFPA contribute to coordination mechanisms in the UN system at country/territory level?

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

Summary findings

UNFPA CO has made consistent positive contributions to the consolidation and functioning of UNCT coordinating mechanisms (working groups and joint programs) toward implementation of the UNDAF in each of the four programme areas. The UNFPA CP's core mandated activities, outputs and outcomes have been integrated into country/territory's UNDAF and recognized and acknowledged by the UNCT. There is no evidence of overlap between UNFPA and other UN agencies at the activity level in the UNDAF and UNCT reports. UNFPA has added value in multiple areas within the country/territory context, most notably in the areas of SRHR and PD.
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UNFPA CO has made consistent positive contributions to the consolidation and functioning of UNCT coordinating mechanisms (working groups and joint programs) toward implementation of the UNDAF in each of the four programme areas. The UNFPA CP's core mandated activities, outputs and outcomes as implemented within the Country's UNDAF are recognized and acknowledged by UNCT. The United Nations Country Team (UNCT) in Bosnia and Herzegovina is comprised of thirteen UN Funds, Programmes and Specialized Agencies (FAO, ILO, IOM, UNDP, UNFPA, UNEP, UNESCO, UNHCR, UNICEF, UNODC, UNV, UN Women, WHO), the Bretton Woods Institutions (World Bank, IMF) and ICTY. The work of the UNCT is being coordinated through the Office of the UN Resident Coordinator and framed within the One UN Programme for Bosnia and Herzegovina 2015-2019(2020) representing the strategic, programmatic and financial basis for the development partnership between the United Nations and the country.

UNFPA has consistently contributed to common country planning and implementation of UNDAF. This was confirmed by analysis of UNDAF documents and implementation plans, as well as through interviews with relevant stakeholders. UNFPA is a regular and active member of all but one Results Group in the UNCT (not represented in Economic Development Results Group), under UNDAF, but stakeholders have particularly emphasized its role in the Social Inclusion Results Group, Youth Task Force, the Coordination Group for Migrant Crisis, and M&E Results Group. It was stressed in stakeholder interviews that UNFPA has consistently managed to raise its profile through work in the Results Groups, despite being a small agency. In some groups, UNFPA has had a convening role (e.g. the M&E group), but it has initiated creating of a Youth Group (2017 COAR). Stakeholders from the UNCT have valued this initiative greatly.

There is evidence that UNFPA participated in the reporting of the UNCT in the period 2015-2017, but the method of reporting has changed at the UNCT level. Namely, the latest, 2017 report, does not single out contributions of individual agencies any more, but reports on UNCT achievements as a whole. Furthermore, it was noted by individual stakeholders that a comprehensive UNDAF evaluation would be conducted in 2019.

UNFPA global mandates are being effectively implemented within the UNDAF in all four program areas. UNFPA strategic priorities have been well represented in UNDAF. UNFPA has regularly participated in drafting of regular biannual joint work plans by developing activities in line with its CPDs and its AWP. It was noted by all stakeholders that UNFPA has managed to integrate its priorities into the UNDAF. However, it was also noted that UNDAF is currently a compilation of multiple priorities for different UN agencies, their headquarters, and their project and programmes. There is an indication that this could change in the future and that the UNDAF should become a more "home-grown" document, identifying needs and priorities of the country, and then asking agencies to contribute to this framework.

UNFPA has cooperated with other UN agencies in delivery of activities and programmes, but there is inconclusive evidence on program complementarity, seeking synergies and avoiding overlaps and duplication of activities among development partners. There are at least two traditionally perceived areas of overlap with other UN agencies, which is with UNWOMEN in the sphere of gender equality, and with UNICEF in the sphere of youth. Some stakeholders said that there has been no overlap at the project activity level, but rather that complementarities and synergies have been established. There is evidence in COARs and stakeholder interviews for joint work with UNICEF

on early marriage prevention, work with UNCHR in the field on protection of GBV victims during migrant crisis, utilization of WHO's BtN methodology alongside clear delineation between mandates for communicable and non-communicable diseases. Another example of joint work is the distribution of intervention areas among four agencies as part of the Joint Programme Seeking Care, Support and Justice for Survivors of Conflict Related Sexual Violence in BiH. Concerning the latter, some stakeholders believe that there was direct overlap at activity level between UNFPA's CRSV work (capacity development of health sector for service provision to survivors, including building referral mechanisms) and UN Women's work on GBV prevention. At the same time, UNFPA's work with perpetrators was overlapping with UN Women's work with perpetrators. There are concerns that the JP has not worked with sufficient synchronization, or rather progress toward a common goal has not been achieved at the same pace by all agencies. It is questionable whether UNFPA can be faulted for this, as individual stakeholders have presented completely diverging views on overall efforts on part of individual UN agencies to coordinate with others and to propose more synergies.

At the same time, it was observed by stakeholders that other UN agencies have started to step into areas where UNFPA was so far almost an exclusive implementer. These areas include youth and ageing, which is why close coordination is necessary in order to ensure complementary actions.

UNFPA has added value in multiple areas within the country context. UNFPA is recognized by stakeholders as a small but lean agency with a very specific mandate. Several topics have made UNFPA highly recognizable and valued in the UNCT and among national stakeholders. It was noted by a majority stakeholders that UNFPA addresses issues that no one else does - SRHR and PD. According to stakeholders, UNFPA keeps the debate and programmes alive in the areas that other agencies, or the society in general, do not find easy to talk about. These are the issues of sexual and reproductive health, sexuality education, sexual and other gender-based violence, stigmatisation of victims of violence. But UNFPA also addresses other generally neglected target groups, such as older persons and their well being. Also, it was observed that no other UN agency has the mandate or capacity to lead on population matters. Stakeholders also valued UNFPA's practice to adapt its global standards and tools in particular areas, such as SRHR and GBV in emergencies, or family planning and improving maternal health, among others, to local context. In general, stakeholders have confirmed that UNFPA CP is unique and greatly adds value to the country's development.

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

UNFPA CO has drafted its Resource Mobilization Strategy for the CP period 2015-2019(2020) in the form of four annual resource mobilization plans (please refer to Annex 3 for list of documents). These plans analyse the CP's financial structure and the donor environment. The plans map potential donors and identify actions in relation to these donors, for UNFPA independently, or in cooperation with other agencies. They identify clearly the key opportunities and obstacles in raising funds for UNFPA activities, noting primarily that the core resources allocated for the CPD are insufficient to achieve set goals and fulfil set targets and indicators. It is also noted that the programmatic areas that constitute the core of UNFPA's mandate, such as sexual and reproductive health and population policies have not been a focus of donor attention in BiH. Opportunities are noted for the donor interest in investing in gender equality and prevention of GBV. The implementation of resource mobilization plans is regularly monitored by the UNFPA CO. There is evidence of CO's continuous efforts to raise funds by proposing project concept notes and submitting project proposals to donors. Project applications for GBV/CRSV with the UK FCO and Disaster Risk Reduction with the Swiss Government have been successful, as well as an earlier application to the United Nations Department of Economic and Social Affairs (UNDESA) for strategies on ageing.

UNFPA Partnership Plans are also drafted every year and they list all partners of UNFPA in delivery of specific interventions in line with the CPD objectives (please refer to Annex 3 for list of documents). The lists are exhaustive and include every institution that participates in UNFPA activities in any way. Each partner's role is described, as well as the expected outcome of partnerships. Plans are regularly

monitored. However, no partnership has been formalized between UNFPA and domestic authorities, which constitute a majority of partners. It could be argued that by signing the UNDAF, domestic authorities agreed to cooperation and partnership with UNFPA too, as part of UNCT, in delivery of agreed products and activities. Also, general practice in the development environment in BiH has shown that signing of formal partnerships between individual organizations and institutions may slow down the beginning of delivery of interventions, which is a risk that should not be underestimated. However, formal individual partnerships could guarantee cooperation in delivery as well as greater sustainability of results.

UNFPA has drafted three advocacy plans on specific issues: comprehensive sexuality education, family planning and population development (please refer to Annex 3 for list of documents). Although they have advocacy elements and define goals and assumptions, these plans do not differ significantly from regular work plans for specific activities and do not plan for ambitious and persistent advocacy activities. Specific plans have not been created for some other interventions that have been met by considerable resistance of stakeholders (either due to their controversial nature, or lack of sufficient domestic capacities), e.g. monitoring of maternal mortality and morbidity, integration of MISP into national preparedness plans, adoption of youth policies, stigma alleviation, or localization of SDGs. There is need for comprehensive advocacy planning for all UNFPA interventions across programmatic areas, with clear communication tactics and products. Apart from advocacy plans, communication plans are created every year, in line with AWP, which could lead to overlap.

CHAPTER 5: Conclusions and recommendations

5.1. Strategic conclusions

Strategic conclusion 1: Criteria - Effectiveness, Efficiency, Sustainability/Programme Area - All

Conclusion 1: UNFPA has limited resources to work across four fully-fledged programmatic areas and on a large number of activities. Most planned interventions within the existing focus areas have been delivered at the level of outputs, but more lasting effects could have been achieved with a focus on fewer outputs and a longer-term vision for embedding results into domestic regulation and practices. The UNFPA CO has been working across four focus areas of CP in BiH delivering advocacy, capacity development and knowledge management. UNFPA has been operating with a rather small budget, and has engaged in a large number of activities given its financial and human resources. This engagement resulted in high visibility of UNFPA among stakeholders in four programme areas, particularly in the areas of SRHR and GE, which have been the most resourced. However, the financial and human resources have been spread far too thin for meaningful, comprehensive and sustainable results to be achieved in individual programmatic areas. The biggest gaps have been observed in the follow up on some delivered interventions in terms of monitoring of implementation of policies and procedures introduced, or replication of good practices and their formal integration into systems at a higher level to ensure sustainability. Implementing partners have been providing technical and logistical support across components, to the satisfaction of most stakeholders, and their capacities have also increased.

Strategic conclusion 2: Criteria - Effectiveness, Efficiency, Sustainability/Programme Area - All

Conclusion 2: UNFPA has a specific mandate, which minimizes the risk of overlap with other UN or other programmes. This mandate should be exploited by placing more focus on interventions that are exclusively parts of the UNFPA core mandate, but in line with the ICPD and SDG agenda. UNFPA has been successful in delivering outputs across its four focus areas and has added value across these areas. However, UNFPA has been the sole assistance provider in the areas of SRHR and PD, which have clear implications on a wide range of target groups, most notably women, youth and older persons, resourced by data collection. Planning needs to take into account guidance from UNFPA Strategic Plans, but with clear prioritization of interventions that are most relevant in BiH context, for which operational partnerships have been established, and which guarantee results and sustainability. Planning also needs to include strategic advocacy and formal partnerships, with thorough assessment of partners' political will and absorption capacities. Resources should not be spent on a great number of partners, or advocacy actions, but rather on achieving fewer and more specific goals. This could make the small office more effective.

Strategic conclusion 3: Criteria - Effectiveness/Programme Area - All

Conclusion 3: There is limited evidence that sufficient attention has been paid to socially excluded groups under the UNFPA CP. UNFPA has been able to deliver outputs targeting general population of women, youth and older persons, and individual marginalized and vulnerable groups, e.g. victims of violence and migrants. Marginalized groups have been addressed in Youth and SRH policies, but there is room for further outreach in practice to specific sub-groups of youth, including girls specifically and at-risk youth, Roma, and people with disabilities.

Strategic conclusion 4: Criteria - Effectiveness/Programme Area - All

Conclusion 4: UNFPA's target setting in the CPD needs to be more informed, realistic and clear. This evaluation found that some targets set under the CPDs have not been carefully planned, which had an impact on the evaluation of the effectiveness of the CP. For example, the targeted number of policies under the Youth component is not verifiable as it is unknown whether the policies should have been only developed, or endorsed. Also, planning the integration of MISP into a national preparedness plan was unrealistic given that it was not feasible to endorse a national preparedness plan. As further illustration, the target number of two civil society initiatives to address early marriage was not ambitious

enough, neither was the adoption of the MIPAA, as evidenced during implementation of CP and results achieved.

Strategic conclusion 5: Criteria - Relevance, Effectiveness, Sustainability/Programme Area - All

Conclusion 5: UNFPA has contributed to creation of several policies and procedures for different population groups, or population-related issues. The adoption of these policies needs to be advocated further, pragmatically and to the extent possible, and support should be provided to domestic institutions for their implementation. UNFPA has supported the drafting of SRH, youth and older persons policies, as well as procedures for GBV response, in line with international requirements. Not all of these policies have been adopted yet, although they could form constituent parts of future population policies. The UNFPA needs to consult existing and newly adopted domestic policies in delivering interventions and quote them in the CPD, so that the CP contributes directly to domestic policies' implementation, thus ensuring buy in from domestic authorities.

5.2. Strategic recommendations

<p>Strategic Recommendation Number 1 (Linked to Strategic Conclusion 1 Programme Area All, Strategic Conclusion 3 Programme Area All and Strategic Conclusion 5 Programme Area All):</p> <p>1.1 UNFPA should consider streamlining its work into two programme areas to capitalize on its core mandates and biggest added values as recognized by stakeholders, while ensuring focus on selected target groups in line with the UNFPA Strategic Plan and local needs. The two components of focus should be on SRHR and PD, with mutual links and synergies established between them for capacity development, knowledge management and advocacy for policy solutions. A decision could be made to focus only one target group (most notably, youth), or more, depending on available resources. The work under components should reflect and build on previous UNFPA deliverables in policy making (SRHR, youth, older persons, including GBV response procedures) in order to contribute to adoption and/or implementation of these policies. This recommendation applies both to core and non-core resources.</p> <p>1.2 The UNFPA needs to coordinate its programmatic actions with UN agencies and other partners (including EU, bilateral donors and their implementing partners) in order to avoid duplication and overlap. UNFPA should keep and regularly update a comprehensive stakeholder register with identified interests and influence of each stakeholder in order to foster partnerships and ensure regular processes of stakeholder management, including required communication and engagement. The UNFPA needs to capitalize on its comparative advantage of expertise in SRHR (including CSE and GBV in emergencies) and PD, as well as actions for adolescent girls and gender transformative actions (as part of initiatives targeting youth). It should capitalize on being recognized as an agency that deals with issues that have not been tackled by other actors. UNFPA should seek synergies with other agencies and coordinate in achieving common goals, by organizing joint activities, if possible.</p> <p>1.3 UNFPA should continue the practice of integrating internationally developed methodologies in BiH. This practice has been valued greatly by domestic partners and it should be upheld with necessary adjustments to the local context. International expertise, provided by international consultants, has also been appreciated. This practice of bringing in international know how, standards and best practices should be maintained. Knowledge should be shared with local staff and associates, whenever possible.</p>	<p>To: Country Office Priority level: High</p>
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<p>Strategic Recommendation Number 2 (Linked to Strategic Conclusion 2 Programme Area All and Strategic Conclusion 4 Programme Area All):</p> <p>2.1 UNFPA should decide which interventions have the biggest potential for long-term development, introducing systemic solutions, which are feasible and could have the necessary buy in from domestic partners, and pursue these interventions. UNFPA should engage in a robust and rigorous planning exercise, which will result in setting of 3-4 long-term goals in line with the UNFPA Strategic Plan and local needs (most notably, increased youth knowledge of SRHR, increased access of young people to SRHR services, changed perception of gender role among youth, increased knowledge of reasons behind youth emigration and policy recommendations, among others possible goals). The goals need to be ambitious, realistic, and have buy in from domestic partners. The targets set should be informed and realistic. These priorities need to be agreed with domestic partners and coordinated with UN agencies and other providers of assistance. Partners should be identified through careful stakeholder analysis and their engagement planned and detailed within the framework of UNDAF and in the process of thorough consultation with stakeholders. A multi-year CPD should be accompanied by tentative multiyear work plans, which could be adjusted at the end of every year for the following year, to allow for a certain flexibility depending on changing context and approved budgets. Having an outline of annual plans for several years at the beginning of CP cycle would ensure sequenced and systematic implementation toward reaching of longer-term goals, as well as better prospects of availability of implementing partners and their better planning.</p> <p>2.2 Sufficient time and resources need to be invested in monitoring and reporting on implementation of plans. A system of monthly reporting by components against set goals should be introduced in order to allow for timely information sharing, management interventions and necessary mitigation. Monthly reports should be internal management tools that are discussed at regular staff meetings as both a self-monitoring and peer review tool.</p> <p>2.3 The practice of drafting and monitoring resource mobilization, partnership and advocacy plans should be upheld and improved with a view of increasing effectiveness. The Resource Mobilization Strategy should be implemented so that the strategy is drafted for the duration of the CPD, monitored on quarterly basis and adjusted on annual basis, as well as upon identification of new opportunities for fund raising. Partnership plans should be continuously drafted and updated, as well as agreed with the key partners for the duration of CPD, taking into account the multi-year planning recommended. Advocacy plans should be consolidated with communications plans and created for every component of work, setting clear and higher-level advocacy goals, identifying the audience, and defining tactics, programmes, and intended results. Component leads should have ownership over planning, implementation and monitoring of the implementation of these plans.</p>	<p>To: Country Office Priority level: High</p>
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5.3. Programme conclusions

Conclusion 1: Relevance/Programme Area - SRHR

The UNFPA CP has been aligned with international and domestic policy frameworks and the needs of individual target groups, mostly women. Existing and new domestic policies in the areas of SRHR and health in general need to be consulted regularly and interventions should be planned accordingly. The needs of specific vulnerable and marginalized groups need to be examined carefully. The UNFPA CP in the SRHR programmatic area has been adapted largely to the needs of women. Although stated as target groups in CPDs, marginalized and vulnerable groups do not feature highly in CP interventions. Persons with disabilities, people at risk of HIV infection, older persons and Roma have largely been neglected. This is not in line with recommendations of 2012 CPE

for the UNFPA in BiH. The UNFPA focused its interventions in the SRHR focus area on introducing services that should be available to overall population that come into contact with the health system. There is room for further assessment of the SRHR needs of individual vulnerable and marginalized groups, particularly of people at risk of HIV infection, given the finalization of the Global Fund programme.

In this SRHR programmatic area, the UNFPA CP has been adapted to international policy frameworks, including the UNFPA Strategic Plans, the ICPD Programme of Action, while the interventions are also pertinent to achieving SDGs. The CP in the area of SRHR has been fully integrated into the UNDAF for BiH. Domestic policies and changes in the political and humanitarian context have been taken into account and stakeholders have confirmed joint and consultative planning of UNFPA interventions. It should be noted that UNFPA has been the sole provider of assistance in the area of SRHR in BiH. There is room for a more detailed examination of domestic policy documents, including SRHR and wider health strategies, for programming of further interventions.

Conclusion 2: Effectiveness, Sustainability/Programme Area - SRHR

UNFPA CP has contributed to creating key underlying assumptions for increased utilization of integrated SRHR services, although not focusing on those furthest behind. Results achieved in FP repositioning should be followed up to ensure full procedural embedding, continuous training, monitoring and evaluation. The unique position of primary health care providers should be tested for embedding of additional SRHR services, including prevention of STIs, including HIV, and systemic reproductive organ cancer screening. There is room for better outreach to marginalized and vulnerable groups, including youth, Roma, and people at risk of HIV infections. Revised domestic SRH policies are expected to be adopted and their implementation will require support. Research into causes of maternal morbidity and mortality, including that of marginalized and vulnerable groups of women, remains pertinent. UNFPA's direct emergency response during floods and migrant crisis has provided a clear evidence base for integration of MISP into preparedness plans, which needs to be further promoted. There is little available evidence to assess the extent to which marginalized groups have utilized SRHR services. It can be concluded that FP training had an effect on the work of primary health providers, who reported that they have been able to provide FP advice to patients and use the knowledge gained in their everyday work. However, there are no guarantees that this practice will be upheld unless FP is formally defined as a procedure, unless continuous training is ensured to make sure that all primary health care providers have the necessary level of knowledge, and unless this knowledge is refreshed and the practice is regularly monitored and assessed for effectiveness. The lack of affordable contraception has been identified as an impediment to effective FP and SRHR services.

The fact that clinical guidelines for maternal health have been developed and endorsed could be interpreted as contributing to increased general availability of integrated SRHR services, although there is a lack of information about access of specific marginalized groups to these services. Furthermore, it is hard to link the maternal mortality and morbidity surveillance interventions with this outcome at the moment, as the implementation of this methodology is still in a nascent phase. Earlier activities on cervical and breast cancer screening have not been followed up. There is room for options to be analysed for the introduction of systemic and regular screening on cervical, breast and prostate cancer.

Under the UNFPA CP, the development of procedures for provision of SRHR services in emergency situations, as well as procedures for treatment of GBV in emergency situations, indicates an orientation toward marginalized groups, in this case migrants (including youth). However, a lot remains to be done for MISP to be formally and systemically integrated into the health system's response emergency situations and crises, which is subject to further work as part of DRR project.

The UNFPA has not focused on rolling out interventions in the area of SRHR that are related to prevention of STIs, including HIV. This is a result of the Global Fund programme implementation by other actors and adjustment to this context. Also, with the lack of recent and reliable data on the population's health, it is challenging to plan evidence-based interventions in the area. However, the

draft SRHR policies for FBiH and RS do plan for measures related to monitoring, prevention of and response to STIs. The UNFPA should support the implementation of these policies.

Conclusion 3: Relevance/Programme Area - Youth

The UNFPA CP has been aligned with international youth policy frameworks and the needs of youth in general, but there is limited evidence that national policy frameworks and the changing local context have shaped the CP. Existing and new domestic policies in the area of Youth and adolescents, as well as major changes in the local context, such as youth emigration, need to be consulted regularly and interventions should be planned accordingly. Needs of specific vulnerable and marginalized groups need to be examined carefully, particularly those of girls and at-risk youth populations. The UNFPA CP in the Youth programmatic area has been adapted largely to the needs of youth, and to Roma youth to some extent. Although stated as specific groups in the CPD 2015-2019(2020), marginalized and vulnerable youth groups do not feature highly in CPD interventions. Rural youth, youth with disabilities, and at-risk youth populations have largely been neglected, while UNFPA supported interventions have focused on introducing policies and services for overall youth population.

The CP in the area of Youth has been integrated into the past two UNDAFs for BiH, but this specific category of population deserved greater and more specific attention in these documents. Youth-specific domestic policies have not been quoted in the CPDs, but stakeholders interviewed generally confirmed the relevance of this programme area in relation to the needs of youth, including beyond only youth health issues. Youth emigration has not been taken into account in CPD planning and interventions. The joint UN youth programming, which is still in its nascent phase, could be an opportunity to take into account this issue related to youth population.

Conclusion 4: Effectiveness, Sustainability/Programme Area - Youth

UNFPA interventions related to sexuality education could gradually lead to increased access of young people to sexuality education. The CSE coverage in BiH is limited to two cantons only, which is far from sufficient. Interventions need to expand in order to ensure wider CSE coverage and increased access to sexuality education. Youth friendly approaches to provision of SRHR services are still in a nascent phase and their effects are yet to be tested. Ways to reach marginalized and particularly vulnerable groups of youth in terms of sexual education and access to SRHR services need to be identified. Planned outputs under this component have been achieved to some extent. This component focused on delivery of sexuality education, youth policy making, and prevention of early marriages. There is no evidence that activities on peer education on SRHR have been replicated or sustained. More systemic efforts are noted in introduction of Comprehensive Sexuality Education in schools, the result of which was the successful integration of this content into primary school classes in Bosnian Podrinje Canton. The interventions related to youth policy drafting in RS and FBiH were only partly successful, as the Youth Policy was adopted only in RS. UNFPA's initiative for development of a UN Youth Strategic Document as yet remains to materialize. Interventions related to prevention of early marriages are embodied in several theatre plays without systemic follow up.

UNFPA has developed a youth friendly services module for training of primary health care providers, but it is uncertain to which extent this type of service provision for youth will be effective given the specific needs of youth population groups. Stakeholders have argued that links between the education and health systems need to be established for effective provision of SRHR services to youth. Activities on SRHR knowledge sharing via the Internet or smartphone applications are plausible and in line with assessment findings on youth learning, but their effectiveness and sustainability are yet to be measured.

Conclusion 5: Relevance/Programme Area - GE

The UNFPA CP in the GE programmatic area has been mostly aligned with international and national policy frameworks and has been able to adapt to local context; the CP has been adapted largely to the needs of women, including some groups of marginalized and vulnerable women,

more specifically victims of GBV and CRSV. Some interventions under the CP have been related to men and boys, and youth in general.

The UNFPA CP has been adapted to international policy frameworks related to GE, including UNFPA Strategic Plans, ICPD Programme of Action, while the interventions are also pertinent to achieving SDGs. The CP in the area of Gender equality has been integrated into the UNDAFs for BiH. There is evidence of alignment with the UNSCR 1325 and CEDAW, as well as domestic gender equality legislation, legislation related to domestic violence, the BiH Gender Action Plan, and BiH's Framework Strategy for implementing the Istanbul Convention. Adjustments have been made in relation to preferences of the entities' health authorities on how to approach procedures for treatment of GBV victims, comprehensively, or specifying the approach for CRSV victims. Under this component, GBV and CRSV are addressed specifically, while there is also evidence of wider gender equality work, e.g. through gender transformative actions.

Conclusion 6: Effectiveness, Sustainability/Programme Area - GE

Mainstreaming of provisions to advance gender equality has been achieved to a good extent. Integration of GBV prevention, protection and response into national sexual and reproductive health programmes is evidence of successful gender mainstreaming. The implementation of practices related to GBV prevention, protection and response into national sexual and reproductive health programmes yet remains to be measured. The same can be argued for integration of stigma alleviating practices into the work of the Inter-religious Council, which requires continued support. Gender transformative actions, such as the work carried out in cooperation with BiH Women's Football Team are also evidence of good gender mainstreaming and this success should be replicated in other spheres of social life, with a view of further analysing and addressing gender stereotypes. Planned outputs under this component have been achieved to a considerable extent. GBV prevention, protection and response was integrated into national sexual and reproductive health programmes as comprehensive resources packages for the health sector's response. These resource packages have been developed and endorsed by the FBiH Ministry of Health and RS Ministry of Health and Social Welfare and the training on the application of these resources had wide coverage. There is evidence that protocols for treatment of GBV victims have been formalized and localized in several local communities. This was coupled with unintended outputs related to alleviating stigma against survivors of CRSV. There is some evidence of gender transformative actions. There have been delays in drafting of the Study of Masculinities and Gender-Based Violence against Women in BiH, but visible results in work with BiH Women's Football Team. Unfortunately, tracking and reporting mechanisms to follow up on the implementation of reproductive rights recommendations and obligations was not established at state and entities level, but has been replaced by an SRHR inquiry starting in 2019.

Conclusion 7: Relevance/Programme Area - PD

The UNFPA programme is mostly aligned with international and national population policy frameworks and the needs of specific population groups, most notably older persons and the migrant population. There is room for a more comprehensive approach to other population groups, including different marginalized groups in order to integrate the issue of social exclusion into rights-based population policies. In this programmatic area, the UNFPA CP has adapted international policy frameworks, including UNFPA Strategic Plans (in the area of population policy development, but not necessarily regarding specific work directed toward older persons), ICPD Programme of Action, while the interventions are also pertinent to achieving SDGs. The CP in the area of PD has been integrated into the UNDAFs for BiH. There are clear links with domestic policies and needs, particularly in relation to monitoring of migration as part of the process of rapprochement with the EU. This also true in relation to treatment of older persons, which is an area that has not been addressed by any other actor in the country. It should be noted that BiH and its entities do not avail themselves of comprehensive population policies.

Conclusion 8: Effectiveness, Sustainability/Programme Area - PD

Developing of evidence-based national population policies has been achieved to a good extent. The successes result mostly from drafting of policies for older persons, youth and SRHR, as well as development of a migration monitoring methodology. However, in this component UNFPA has not been able to rely on, or generate sound data, in order help domestic institutions use this data for population policy making. There is need for UNFPA, as an agency with a specific population-related mandate, to maximize its role in direct data collection as well as support to domestic institutions in the development of sound methodologies for data collection, in line with international standards, including ICPD and SDGs requirements. The outputs under PD component of UNFPA CP have been achieved to some extent. Migration statistics methodology and software were developed in cooperation with the Security Ministry, but these resources have not been put to use. The drafting of Strategies for improving the Status of Older Persons in RS and FBiH has been completed, and these strategies are awaiting adoption. This activity has been aligned with the Madrid International Plan of Action on Ageing, which was signed by BiH. A number of Healthy Ageing Centres have been established in BiH, some of which report good results. Specific population situation and projections analysis are underway, but so far UNFPA did not have resources to lead on data collection activities, which are vital for evidence-based population policy development. There is potential for revitalizing the migration database, as information from this database could significantly inform policy making. The same applies to Population Situation Analysis and Population Projections work.

5.4. UNCT Coordination and UNFPA Added Value Conclusions

Conclusion 1: UNFPA CO has made consistent positive contributions to the consolidation and functioning of the UNCT coordinating mechanisms (results groups, task forces and joint programmes) toward implementation of the UNDAF in each of the four program areas. The UNFPA CP's core mandated activities, outputs and outcomes as implemented within the Country's UNDAF are recognized and acknowledged by the UNCT. UNFPA has been an active member of majority of Results Groups and has led the M&E Results Group and the Youth Task Force.

Conclusion 2: UNFPA has cooperated with other UN agencies in delivery of activities and programmes, but there is inconclusive evidence on program complementarity, seeking synergies and avoiding overlaps and duplication of activities among development partners. There are perceived thematic overlaps with other UN organizations, most notably in the areas of youth and gender equality. As part of the Joint Programme Seeking Care, Support and Justice for Survivors of Conflict Related Sexual Violence in BiH, lack of synchronization of results within the JP has been reported, in terms of difficulties in consolidating overall JP results. There are concerns that the JP has not worked with sufficient synchronization, or rather progress toward a common goal has not been achieved at the same pace by all agencies. It is questionable whether UNFPA can be faulted for this, as individual stakeholders have presented completely diverging views on overall efforts on part of individual UN agencies.

Conclusion 3: UNFPA has added value in multiple areas within the country context, and these areas are primarily the SRHR and PD. It was noted by stakeholders that topics under these two components have not been addressed by any other actor in BiH and that without UNFPA the issues of SRHR and ageing would be completely neglected.

5.5. Programme recommendations

The following recommendations should be considered as a list of options and selected for implementation based on resources available and prioritization of needs in line with the domestic policies, needs and established partnerships. Recommendations are given for all four CP components, although it is recommended above, under strategic recommendations, that the CP be reduced to two components. In line with this strategic recommendation, difference levels of priority are suggested. The recommendations given the highest priority are related to SRHR and PD in relation to the specific target group of youth.

<p><u>Recommendation 1</u> (Linked to SRHR Conclusions 1 and 2): UNFPA should continue to work on family planning in order to reduce the number of abortions and unmet need. Family planning needs to be embedded more deeply into the primary health care service, as well as promoted more widely among the general public, and among specific subgroups of the population. Trainings on family planning should become part of the continuous training of primary health care providers across the country. There needs to be continuous evaluation of implementation of this training in practice and delivery of services. UNFPA should identify ways to ensure wide, continuous and if possible, mandatory training for primary health care professionals on family planning. Given that primary health care doctors usually have little time for training and that it is difficult to include all doctors in in-person training, innovative ways of training delivery could be explored, e.g. online training modules, which would be endorsed by institutions in charge of medical training and certifications. UNFPA should consider working with the FBIH Agency for Quality and Accreditation in the Health Sector and the RS Agency for Certification, Accreditation and Improving Quality of Health Care to support evaluation of implementation of family planning counselling in practice and planning improvements. Family planning repositioning should be publicized widely in order to create demand.</p> <p>The medium priority is given because of extensive work that had been done under previous CPs and the expectations that this intervention could be followed up in the remaining years of CPD 2015-2019(20).</p>	<p>To: Country Office Priority level: Medium</p>
<p><u>Recommendation 2</u> (Linked to SRHR Conclusions 1 and 2): UNFPA should continue work on introduction of breast, cervical and prostate cancer screening. UNFPA should support partner institutions in analysing the cost of cancer treatment and cancer screening and use this information for advocacy. Introduction of screenings has been envisaged as a strategic measure in the proposals for SRHR policies in FBiH and RS, and when these policies are adopted, the domestic partner institutions will require substantial assistance. UNFPA should not commit to introducing systemic screening, but should agree with partners on a roadmap toward achieving this goal.</p> <p>The medium priority is given the fact that considerable funds would need to be invested even in the cost analysis of cancer treatment versus cancer screening as a preventative action.</p>	<p>To: Country Office Priority level: Medium</p>
<p><u>Recommendation 3</u> (Linked to SRHR Conclusions 1 and 2): UNFPA should adjust its interventions to the needs of specific groups of population, including marginalized and vulnerable groups and develop tailor-made interventions for these groups. Since it is known that primary health care service providers have designed their services for general population, UNFPA should design specific modules for service provision to marginalized or vulnerable groups, including primarily youth and sub-categories of youth, and plan for specific outreach activities. This intervention should be in line with SRHR and youth policies, as well as lessons learned from CP implementation. It should be assessed whether family medicine is the best venue for provision of SRHR services to youth, or it is worthwhile investing in youth/student clinics.</p> <p>High priority is given as a result of earlier lack of attention to marginalized and vulnerable groups, including youth and high relevance of youth health for population development.</p>	<p>To: Country Office Priority level: High</p>
<p><u>Recommendation 4</u> (Linked to SRHR Conclusions 1 and 2): UNFPA should continue to work on maternal mortality and morbidity surveillance. Although BiH is a country with low maternal mortality, UNFPA should continue to support improvement of a system for surveillance, including analysis of</p>	<p>To: Country Office</p>

<p>maternal mortality and morbidity and the response to them, which is adapted to the local context, at least at the level of pilot institutions that had already been approached. Although this system has so far been seen as controversial, the UNFPA should develop a specific advocacy plan around this topic and implement it consistently with the final aim of demonstrating and publicizing how the surveillance system works, which are its effects and benefits, and how it could be integrated into health policies and systems.</p> <p>Low priority is given as a result of low maternal mortality in BiH, risks of unavailability of willing institutions for piloting, and the expectation that this intervention will be followed up in the remaining years of CPD 2015-2019(20).</p>	<p>Priority level: Low</p>
<p>Recommendation 5 (Linked to SRHR Conclusions 1 and 2): UNFPA should continue to work on the integration of MISP into health sector’s response to emergencies, and the prevention and response to GBV in emergencies. UNFPA should take stock what has been achieved as a result of its interventions related to MISP and the prevention and response to GBV in emergencies: what were the lessons learned, and what remains to be done for systemic integration of minimal standards into preparedness plans in terms of regulatory, institutional and organization framework, including ensuring there are sufficient trained individuals and sufficient supplies. The BiH MISP Readiness Action Plan should be consulted and measures delivered, or advocated, to ensure that relevant institutions have a sufficient and continuous level of preparedness to respond in emergencies.</p> <p>Medium priority is given because of extensive work that had been done under previous CPs and the expectations that this intervention could be followed up in the remaining years of CPD 2015-2019(20).</p>	<p>To: Country Office Priority level: Medium</p>
<p>Recommendation 6 (Linked to SRHR Conclusions 1 and 2): UNFPA should continue to work on embedding CSE in the school curricula in FBiH and RS. This intervention is not without risks, so UNFPA should capitalize on the results achieved so far, based on the lessons learned, to avoid excessive costs. This could entail replication of the training materials for primary school teachers and investing in development of curriculum and training materials for secondary schools. UNFPA should develop a specific advocacy plan around this topic and implement it consistently with the final aim of integrating sexual education into school curricula. UNFPA should monitor and evaluate the results of its previous informal sexual education initiatives, including online sources (website and smartphone application), and follow up on these efforts with new innovative solutions, e.g. production and screening of relevant video products for schoolchildren and wider, along with special products for socially excluded youth and adolescents.</p> <p>High priority is given as a result of earlier lack of attention to marginalized and vulnerable groups, including youth and high relevance of youth health for population development. Also, very few other local or international actors have engaged in such interventions.</p>	<p>To: Country Office Priority level: High</p>
<p>Recommendation 7 (Linked to Youth Conclusions 1 and 2): UNFPA should help relevant institutions implement priorities related to sexuality education and SRHR services from FBiH and RS strategic documents for improvement of sexual and reproductive health and rights. In line with SRHR Recommendation 3. above, UNFPA should assess which is the best way to offer SRHR services to young people, by taking stock of the lessons learned through the Global Fund programme, other initiatives, as well as its own family planning repositioning interventions.</p> <p>High priority is given as a result of earlier lack of attention to marginalized and vulnerable groups, including youth and high relevance of youth health for population</p>	<p>To: Country Office Priority level: High</p>

development. Also, very few other local or international actors have engaged in such interventions.	
<p>Recommendation 8 (Linked to Youth Conclusions 1 and 2): UNFPA should focus on the empowerment of girls and transformation of gender roles. UNFPA BiH should design specific interventions to empower girls in line with UNFPA’s Action for Adolescent Girls, adjusted to local context. This intervention should include careful stakeholder mapping and engagement planning, following identification of at-risk groups and their needs. The work with adolescent girls should be paralleled by gender transformative actions with boys, resourced by actions on prevention of unwanted pregnancies, STIs, including HIV/AIDS, among youth (above under SRHR recommendation 6.) and specific actions for prevention of GBV.</p> <p>High priority is given as a result of earlier lack of attention to marginalized and vulnerable groups, including youth and high relevance of transformation of gender roles perception at early age. Also, very few other local or international actors have engaged in such interventions.</p>	To: Country Office Priority level: High
<p>Recommendation 9 (Linked to GE Conclusions 1 and 2): UNFPA should embed GBV and CRSV response training into training programmes for health professionals and monitor the application of these procedures in a manner agreed with the FBiH Ministry of Health and the RS Ministry of Health and Social Welfare, given their preferred approach to GBV victims. Identification of GBV and CRSV victims and their treatment by the health system needs to be embedded more deeply into primary health care service, including centres for mental health. Trainings on GBV and CRSV response should become part of continuous training of primary health care providers and there needs to be continuous evaluation of implementation in practice and delivery of services. UNFPA should identify ways to ensure wide, continuous and if possible, mandatory training for primary health care professionals on GBV and CRSV response. Given that primary health care doctors usually have little time for training and that it is difficult to include all doctors in in-person training, innovative ways of training delivery could be explored, e.g. online training modules, which would be endorsed by institutions in charge of medical training and certifications. UNFPA should consider working with the FBiH Agency for Quality and Accreditation in the Health Sector and the RS Agency for Certification, Accreditation and Improving Quality of Health Care to support evaluation of implementation of procedures for GBV and CRSV victims and planning improvements and replication across primary health care institutions.</p> <p>Medium priority is given because of extensive work that had been done under previous CPs and the expectations that this intervention will be followed up in the remaining years of CPD 2015-2019(20).</p>	To: Country Office Priority level: Medium
<p>Recommendation 10 (Linked to GE Conclusions 1 and 2): UNFPA should follow up on its work to alleviate stigma against GBV and CRSV victims by delivering focused, yet comprehensive, solutions. UNFPA should identify, based on its experience and lessons learned so far, who are the most influential opinion-makers among the general public and engage in focused activities for the alleviation of stigma against victims of GBV and CRSV. These could be religious officials, teachers, media, or others, but it is important that selected partners have relatively wide reach. Stigma alleviation activities could be combined with, or supplemented by, gender transformative actions under Youth Recommendation 2 above. If UNFPA decides to work at the local level, stigma alleviation activities should be implemented in areas where GBV referral systems have been established, so that the direct effects on victims of GBV and their protection could be measured. If UNFPA decides to work with selected partner institutions or organizations with wider reach, e.g. entity, or state-wide reach,</p>	To: Country Office Priority level: Low

<p>tools for the measurement of success, such as changing of attitudes, should be designed and utilized.</p> <p>Low priority is given due to difficulties in achieving sustainable solutions.</p>	
<p>Recommendation 11 (Linked to PD Conclusions 1 and 2): UNFPA should contribute to better population data collection. UNFPA should plan and implement specific, but smaller scale data collection activities to help relevant institutions avail themselves of reliable information on demographics, including migration, and health. The advocacy for data collection is not sufficient in the current context, where domestic partners lack resources for specific surveys and other data collection activities. Resources should be mobilized and allocated for conducting of specific surveys, along with development of methodologies and training of statistical institutions in applying these methodologies for the purpose of ensuring an evidence base for policy making and sustainability of results. Along with this, UNFPA should take active part in translating SDGs that are pertinent to its mandate into domestic context and promoting the ICPD agenda and relevant data collection, in coordination with other UN agencies. Data collection efforts should be developed in the way to systemically record the status, needs and risks of socially excluded or otherwise marginalized or vulnerable groups.</p> <p>Medium priority is given because of extensive work that had been done under previous CPs and the expectations that this intervention will be followed up in the remaining years of CPD 2015-2019(20). Also, the inherent costs of these interventions are expected to be high.</p>	<p>To: Country Office Priority level: Medium</p>
<p>Recommendation 12 (Linked to PD Conclusions 1 and 2): UNFPA should invest targeted effort in surveying the magnitude and reasons for youth emigration and assist domestic authorities in creating evidence-based policies. Research results should be promoted widely and solutions advocated with relevant stakeholders, including partners in UN youth programming. Results achieved under the earlier YERP should be consulted and follow up measures delivered at the policy level, resourced by knowledge management and dissemination of reliable information.</p> <p>High priority is given as a result of earlier lack of attention to marginalized and vulnerable groups, including youth and high relevance of youth emigration for population development. Also, very few other local or international actors have engaged in such interventions.</p>	<p>To: Country Office Priority level: High</p>
<p>Recommendation 13 (Linked to PD Conclusions 1 and 2): UNFPA should support monitoring of policies for SRH, youth and ageing and advocate further drafting of comprehensive population policies. UNFPA should support domestic institutions in developing and implementing robust monitoring of existing and future policies created with the help of UNFPA. This could involve setting up and supporting monitoring bodies in entities, or supporting processes of yearly reporting on implementation of adopted strategies, along with relevant data collection efforts mentioned above. At the same time, UNFPA should identify the key stakeholders and create engagement and advocacy plans with the aim of securing institutions' agreement to start working on comprehensive population policies.</p> <p>Low priority is given because of extensive work that had been done under previous CPs and the expectations that this intervention will be followed up in the remaining years of CPD 2015-2019(20).</p>	<p>To: Country Office Priority level: Low</p>

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ANNEXES

Annex 1 Terms of Reference



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

A. INTRODUCTION

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

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

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

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

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

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

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

B. CONTEXT

a. Country/territory Profile

Bosnia and Herzegovina

Bosnia and Herzegovina (BiH) consist of two entities (Federation of Bosnia and Herzegovina (FBiH) and Republika Srpska (RS)), and the Brcko District of Bosnia and Herzegovina (BD). Each of the entities and BD have own governments and parliaments/assemblies while at the state level there is the tripartite Presidency of BiH, the Council of Ministers of BiH and bicameral Parliamentary Assembly of BiH. FBiH is further divided into 10 cantons that have major responsibility for development of economic, health, education and social protection sectors. Finally, entities are divided into municipalities; 79 in FBiH and 68 in RS. In line with the 2013 Census report, the total number of citizens in BiH is 3.531.159¹⁰⁶. Population growth has a negative trend since 2007, while the fertility rate remains one of the lowest in the world. Population migrations to developed countries are also underway, where mostly young, skilled people dissatisfied with the current socio-political situation leave BiH, causing a major brain drain. Finally, UN estimates BiH will have at least 30% of persons over 65 years of age by mid-century.

The Republic of North Macedonia

Based on population estimates, the country had over 2 million inhabitants in 2017¹. The population is increasingly aging and the total fertility rate (TFR) is 1.50 live births per woman in the last few years, which is below the replacement rate. The 2002 Census was the last census undertaken in the country and it was evaluated by the international community as well organized. The country was granted EU candidate status since 2005, with accession talk to start 2019, if all agreed political steps with neighboring countries and international community are put in place.

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

¹⁰⁶ The 2013 Census Report, although officially recognised by the BiH Agency for Statistics and the FBiH Institute for Statistics, as well as by the members of the International Monitoring Missions (including Eurostat, UNFPA, UNSD and UNECE), has been disputed by the RS Institute for Statistics for the reason of disagreement over the methodology used for data processing. Instead, the RS Institute for Statistics has developed own Census report that is in use in this entity. By the time this ToR is developed, there has been no agreement between government institutions on how this issue will be solved so different administrations are using different census results.

human resources and poor quality of care. The regulatory-administrative system for evidence-based clinical governance is in rudimentary stages.

Gender inequality and reproductive health and rights in the country are still lagging behind compared with the EU countries. Acceptance of domestic violence (DV) is closely associated with a woman's education level. Due to the societal gender social norms, especially vulnerable to gender based violence are members of the young key populations (defined as MSM, sex workers, PWID, PLHIV). Furthermore, these are especially vulnerable to HIV and other STIs. The harmful practice of early marriage, formal and informal, prevents girls from finishing education, acquiring skills and competences to work, thus making them more vulnerable to poverty and social exclusion.

The Republic of Serbia

The Republic of Serbia was granted status of the EU candidate country in 2012, and current reforms and all national policies are marked with the efforts to fulfill conditions for EU accession. Territory of Serbia is divided into regions which do not have any administrative power or legal subjectivity, but are functional territorial units for the purposes of regional planning and policy implementation. Within these regions Serbia is further divided into districts including the City of Belgrade as one district, and within districts into municipalities and cities which are the administrative units of local self-government. According to official estimation there were 7,058,322 inhabitants in 2016¹⁰⁷. Serbia has been facing unfavorable demographic trends: low natality rate, negative natural growth rate, slow increase in life expectancy, ageing (average age is 42,9) and increase in share of population aged 65 years and over, but also high level of internal migrations from rural to urban areas and emigration, resulting in overall negative migration balance.

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

Kosovo

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

¹⁰⁷Statistical Office of Serbia (2017) *Demographic Yearbook 2016*, Belgrade.
<http://www.stat.gov.rs/WebSite/public/PublicationView.aspx?pKey=41&pLevel=1&pubType=2&pubKey=4225>

According to the 2011 Census the population is 1.7 million with 60 per cent in rural areas. Northern Kosovo municipalities did not participate in the 2011 census. Total number of households is 300,000 with the average household size of 6 members. One out of every four Kosovars lives abroad and it is estimated that over 50,000 migrated illegally in 2015. Around 50 per cent of population is under the age of 25 and only 6 per cent over 65 years. The Total Fertility Rate is approx two children per women and the annual rate of population growth is 0.9 per cent. Life expectancy at birth is 70.2 years, 10 years lower than the European Union.

b. UNFPA Programmes

Bosnia and Herzegovina

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

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

The Republic of North Macedonia

UNFPA is present in the country since 2007 and the first UNFPA five year Country Program Document (CPD) 2016-2020, developed with the Government and other partners, was approved by the Executive

Board in 2015. CPD's main focus is enhancing sexual and reproductive health and rights, and address gender based violence, with focus on youth and improving the use of population information in development policies.

The UNFPA financial commitment over 5 years towards the programme was approved at \$ 1.5 million from regular resources (\$ 1.1 million for sexual and reproductive health and rights component, \$ 0.1 million for adolescents and youth component, \$ 0.1 million for population dynamics component, and \$ 0.2 million for programme coordination and assistance). UNFPA also committed to mobilize \$ 1 million from other resources to co-fund the programme. By mid-2018, UNFPA office has managed to fundraise over \$ 0.5 million, mostly for the humanitarian preparedness and response in the period 2015-2016 from internal, UNFPA and donor resources, and, SRH and GBV activities and support to PwD.

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

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

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

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

The Republic of Serbia

The work of UNFPA in Serbia started in 2006, guided by UNDAF framework. The first UNFPA five year Country Program Document (CPD) 2016-2020 was developed in 2015, in line with UNDAF (2016-2020) and the UNFPA Strategic Plan 2014-2017. CPD's is concentrated on three areas: 1. Sexual and reproductive health services and rights; 2. Policies and programmes related to adolescents and youth

and 3. Evidence based policies addressing population dynamics. Activities envisaged in CPD are being implemented through cooperation with all relevant governmental institutions, academia experts associations, UN Agencies and CSOs.

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

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

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

Kosovo

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

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

The Sexual And reproductive Health initiatives will focus on advocacy and policy dialogue, knowledge management, and capacity building for strengthening evidence-based health policy-

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

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

C. OBJECTIVES AND SCOPE OF THE CLUSTER EVALUATION

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

The specific objectives:

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

The evaluation (including country/territory case studies) will cover all activities planned and/or implemented during the period: Bosnia and Herzegovina 2013-2018, The Republic of North Macedonia 2010-2018, The Republic of Serbia 2010-2018, and Kosovo 2010-2018 within each programme: sexual and reproductive health and rights, adolescent and youth, population dynamics, gender equality and humanitarian response, and cross-cutting areas: partnership, resource mobilization, and communication). **The scope of the evaluation is extended beyond the current programme period to assess achievement/non-achievement of higher level development results.** Besides the assessment of the intended effects of the programme, the evaluation also aims at identifying potential unintended effects. The cluster evaluation should analyze the achievements of UNFPA against expected results at the output and outcome levels, its compliance with the UNFPA Strategic Plans for 2014-2017 and 2018-2021, the UN partnership Framework, and national development priorities and needs.

The evaluation will reconstruct the programme intervention logic and assess the extent to which the ongoing programmes have chosen the best possible modalities for achieving the planned results in the current development context. The evaluation will examine the programmes for such critical features as relevance, effectiveness, efficiency, sustainability, UN coordination, and added value. The evaluation will apply appropriate methodology including UNEG Handbook for Conducting Evaluations of Normative Work in the UN System¹⁰⁸ for assessing the equity and vulnerability, gender equality¹⁰⁹, human rights in development and humanitarian programme¹¹⁰.

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

D. EVALUATION CRITERIA AND EVALUATION QUESTIONS

¹⁰⁸ UNEG Handbook for Conducting Evaluations of Normative Work in the UN System, <http://www.uneval.org/document/detail/1484>

¹⁰⁹ Integrating Human Rights and Gender Equality in Evaluations, UNEG, <http://www.uneval.org/document/detail/1616>

¹¹⁰ Equity focused evaluation: https://mymande.org/sites/default/files/EWP5_Equity_focused_evaluations.pdf

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

Relevance:

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

Effectiveness:

- To what extent have the intended programme outputs been achieved? To what extent did the outputs contribute to the achievement of the planned outcomes (i. increased utilization of integrated SRH Services by those furthest behind, ii. increased the access of young people to quality SRH services and sexuality education, iii. mainstreaming of provisions to advance gender equality, and iv. developing of evidence-based national population policies) and what was the degree of achievement of the outcomes?
- To what extent has UNFPA contributed to an improved emergency preparedness in BiH, The Republic of North Macedonia, the Republic of Serbia, and Kosovo, and in the area of maternal health / sexual and reproductive health including MISP?
- To what extent has each office been able to respond to emergency situation in its AoR, if one was declared? What was the quality and timeliness of the responses?

Efficiency:

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

Sustainability:

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

UNCT Coordination:

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

Added value:

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

E. METHODOLOGY AND APPROACH

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

Data Collection

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

Retrospective and Prospective Analysis

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

Validation mechanisms

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

Stakeholders participation

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

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

F. EVALUATION PROCESS

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

1) Preparation

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

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

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

2) Design phase

This phase will include:

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

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

questions, and should convincingly illustrate how the evaluators intend to carry out the evaluation and ensure its quality.

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

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

3) Field phase

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

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

4) Synthesis phase

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

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

5) Dissemination and follow-up

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

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

G. EXPECTED OUTPUTS/ DELIVERABLES

The evaluation team will produce the following deliverables:

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

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

Work plan/ Indicative timeframe

Phases/Deliverables	Dates
1. Drafting and approval of the ToRs <ul style="list-style-type: none"> - <i>Evaluation ToR</i> - <i>ToR for the Evaluation Steering Committee</i> - <i>TOR for international evaluator</i> - <i>TORs for local evaluators, experts and assistants</i> - <i>TOR for the Evaluation Reference Group(s)</i> 	July 2018
2. Recruitment/vetting of international and national experts	August - October 2018
3. Training workshop for national evaluators (5 days)	4th week of October 2018
4. Design phase: <ul style="list-style-type: none"> - <i>Submission of the design report</i> 	August - October 2018 4th week of October 2018
5. Field phase <ul style="list-style-type: none"> - <i>Bosnia and Herzegovina</i> - <i>Kosovo</i> - <i>The Republic of North Macedonia</i> - <i>Serbia</i> 	November 2018 - February 2019 November - December 2018 December 2018 - January 2019 January - February 2019 January - February 2019
6. Synthesis phase (evaluation report + case studies): <ul style="list-style-type: none"> - <i>1st draft case study for Bosnia and Herzegovina and presentation to Steering Committee</i> - <i>1st draft case study for Kosovo and presentation to Steering Committee</i> - <i>1st draft case study for The Republic of North Macedonia and Serbia, and presentation to Steering Committee</i> - <i>2nd draft case studies (for all 4 COs)</i> - <i>Draft cluster evaluation report</i> - <i>Dissemination seminars (in all four COs)</i> - <i>Final evaluation report and all four case studies (BiH, The Republic of North Macedonia, Serbia, Kosovo)</i> 	January - mid-June 2019 Mid-January 2019 Mid-February 2019 End of March 2019

	<p><i>3 weeks from presentation of 1st drafts</i></p> <p><i>1st week of May 2019</i></p> <p><i>March - May 2019</i></p> <p><i>Mid-June 2019</i></p>
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H. COMPOSITION AND QUALIFICATION OF THE EVALUATION TEAM

The evaluation team will consist of:

- a) **A Team Leader** with overall responsibility for development of cluster design report, facilitation of a training on evaluation design, field data collection, data analysis and submission of country/territory case studies. Furthermore, s/he will lead and coordinate the work of the National Evaluation Team in the field phase and will be responsible for drafting of case studies together with national evaluators, as well as the quality assurance of all evaluation deliverables. Finally, s/he will be responsible for writing draft/final evaluation report. S/he will be in regular contact with the Evaluation Team remotely via Internet to get updates on the field work progress. In case s/he decides that the collected information is not sufficient or of good quality, s/he may request national evaluators to conduct additional interviews with key stakeholders or, as a last resort, s/he may travel to the country/territory for preparing the draft country/territory case studies. The Evaluation Team Leader should have the following qualifications:
- Advanced degree in social sciences, political sciences, economics or related fields;
 - Minimum 7 years of experience of complex evaluations in the field of development aid for UN agencies and/or other international organizations in the position of lead evaluator,
 - Specialization in one of the programmatic areas covered by the evaluation (reproductive health and rights, gender equality, population and development, adolescent and youth policies)
 - Demonstrated ability and knowledge to collect and analyze qualitative and quantitative data (a training on data analysis using software e.g. SPSS);
 - Good knowledge and experience of programme evaluation in the humanitarian settings will be strong assets
 - Knowledge of demographic, political, social and economic conditions in the Western Balkans (preferable);
 - Familiarity with UNFPA or UN programming;
 - Excellent writing and communication skills;
 - Excellent command of both spoken and written English is required.
- b) **Four national evaluators** (one in each office) with overall responsibility for coordinating field data collection, data analysis, drafting of Country/territory Case studies with the Team Leader, and providing support to the Team Leader with drafting cluster evaluation report in addition to collecting data for one substantive component. Each national evaluator should have expertise in at least one of the core subject area/s of the evaluation - Sexual and Reproductive Health, Gender-based Violence or

Population Dynamics. National evaluators will also facilitate evaluation dissemination seminars and will assist the Team Leader in embedding comments from these seminars into the Case Studies and joint evaluation report. Besides personal expertise in conducting complex programme evaluations, the evaluators should have a good knowledge of the national development context and be fluent in the local language and English.

- Advanced degree in social sciences, medicine, public health, women's studies, gender equality, population studies, demography, statistics or related fields;
 - At least 5 years of experience in conducting evaluations as a member of evaluation team or individual evaluator for UN agencies and/or other international organizations;
 - Demonstrated ability and knowledge to collect qualitative and quantitative data;
 - Knowledge of demographic, political, social and economic conditions in the area in which the evaluation will be conducted;
 - Familiarity with UNFPA or UN programming;
 - Excellent writing and communication skills;
 - Fluency in local and English Language.
- c) **National experts** (two or more in each office), who will each provide expertise in one programmatic area of the evaluation. The expert will take part in the data collection and analysis work, and will provide substantive inputs into the evaluation processes through participation at methodology development, meetings, interviews, analysis of documents, briefs, comments, as advised and led by the National Evaluator and Evaluation Team Leader. The modality and participation of experts in the evaluation process, including participation in interviews/meetings, provision of technical inputs and reviews of the design report, drafting parts of the evaluation reports, will be agreed by the Evaluation Team Leader and done under her/his supervision and guidance. The necessary qualifications of the evaluators will include:
- Advanced degree in social sciences, medicine, public health, women's studies, gender equality, population studies, demography, statistics or related fields;
 - At least 5 years of experience in implementing initiatives in at least one of the core subject area/s of the evaluation - Sexual and Reproductive Health, Gender-based Violence or Population Dynamics;
 - Demonstrated ability and knowledge to collect qualitative and quantitative data;
 - Knowledge of demographic, political, social and economic conditions in the area in which the evaluation will be conducted;
 - Familiarity with UNFPA or UN programming;
 - Excellent writing and communication skills;
 - Fluency in local and English Language.
- d) **Four research assistants** (one in each cluster office) that will collect, compile and analyze available data relating to four cluster countries/territory in a form of the database. They will also be responsible for contacting relevant evaluation stakeholders and arranging field work for national evaluators, and logistical support for preparation of dissemination seminars. Besides personal expertise in conducting researches, the assistants should have a good knowledge of the national development context and be fluent in the local language and English. Research assistants will be supported and supervised by evaluation managers in each office.
- Bachelor's degree in statistics, social sciences, population studies, economics or related fields;

- Minimum 2 years of experience in data collection and analysis (with the use of the relevant statistical software packages);
- Knowledge of qualitative/quantitative research methods;
- Familiarity with UNFPA or UN operations;
- Fluency in written and spoken English

The Evaluation Team will conduct the evaluation in accordance to the “Handbook on How to Design and Conduct a Country Programme Evaluation at UNFPA” and their work will be guided by the Norms and Standards established by the United Nations Evaluation Group (UNEG). Team members will adhere to the Ethical Guidelines for Evaluators in the UN system and the Code of Conduct, also established by UNEG. The evaluators will be requested to sign the Code of Conduct prior to engaging in the evaluation exercise.

Remuneration and duration of contract

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

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

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

Team Leader:

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

National Evaluators:

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

National Experts:

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

Research Assistants:

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

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

I. MANAGEMENT AND CONDUCT OF THE EVALUATION

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

The Evaluation Steering Group:

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

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

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

The Evaluation Manager in each office will:

- Conduct initial stakeholder mapping and develop an Atlas project list for his/her office;
- Develop invitation and contact relevant local stakeholders for participation in the Evaluation Reference Group;
- Support the Evaluation Team in designing the evaluation;
- Provide ongoing feedback for quality assurance during the preparation of the design report and draft and final evaluation report with Case Studies;
- Provide research assistant with available internal and external data relevant to the programme evaluation;
- Liaise with the RO M&E adviser aimed to sharing evaluation updates or requesting evaluation assistance.

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

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

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

Bibliography and resources

For Bosnia and Herzegovina:

https://drive.google.com/drive/folders/1tUsvjW19OwKH5GM7Q1N2BNVh_v4k1qs_?usp=sharing

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

[WVF2bd-XooNpIFjgQv?usp=sharing](https://drive.google.com/drive/folders/1wEzxbaK3BDXwL-WVF2bd-XooNpIFjgQv?usp=sharing)

For Kosovo:

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

For Serbia:

<https://drive.google.com/drive/folders/1z7Per3XP8x3KQm6E4gtpQ7dkSEz1SGaC?usp=sharing>

Annexes

Annex - Ethical Code of Conduct for UNEG/UNFPA Evaluations

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

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

For details on the ethics and independence in evaluation, please see UNEG Ethical Guidelines and Norms for Evaluation in the UN System

<http://www.unevaluation.org/search/index.jsp?q=UNEG+Ethical+Guidelines>

http://www.unevaluation.org/papersandpubs/documentdetail.jsp?doc_id=21

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

Annex 2 List of persons/institutions interviewed

Arslanagić, Faruk		Ministry of Security of Bosnia and Herzegovina	M
Dr Barišić, Tatjana	Gynaecologist	University Clinical Hospital Mostar	F
Bašić-Čatić, Sejdefa Blagojević, Željko	Executive Director PD and M&E Programme Analyst	Partnership for Public Health UNFPA BiH	F M
Dr Bologa, Doina	Country Director for Bosnia and Herzegovina, Serbia, Kosovo and the Republic of North Macedonia.	UNFPA BiH	F
Borovac, Amira	Assistant Minister	Ministry for Education, Youth, Science, Culture and Sports of the Bosnian-Podrinje Canton	F
Dr Čengić, Edin	Director; Gynaecologist	Health Centre Goražde	M
Dr Čerkez, Goran	Assistant Minister	Federal Ministry of Health	M
Đukić, Biljana	Family medicine doctor	Banja Luka Health Centre	F
Dr Đurić, Dijana	Psychologist	Center for Physical Medicine and Rehabilitation	F
Džumhur, Jasminka	Human Rights Ombudswoman	Institution of the Human Rights Ombudsman of Bosnia and Herzegovina	F
Eriksson, Anne-Christine	Representative in BiH	UNHCR BiH	F
Gušić, Hatidža	Project Coordinator	Media centar	F
Dr Hadžić, Behzad	Neuropsychiatrist	Center for Mental Health Ključ	M
Hasić, Zijad	Secretary to the Group	Parliamentary Assembly of Bosnia and Herzegovina	M
Hidanović, Sabina	Access to Justice Coordinator	UNDP BiH	F
Husić, Lamija	Assistant Minister	Ministry for Education, Science and Youth of the Canton Sarajevo	F
Dr Imamović, Enida	SRH and Youth Programme Analyst	UNFPA BiH	F
Injac, Danijela	Head of Department	Republika Srpska Ministry of Economic Relations and Regional Cooperation	F
Dr. Ivančić, Ljiljana	Assistant Minister	Ministry of Health and Social Welfare of Republika Srpska	F
Dr Jatić, Zaim	Chairman	Association of Family Medicine Doctors	M
Jovanović, Olivera	Executive Secretary	Interreligious Council	F
Jukić, Velimir	Director	Bosnia and Herzegovina Agency for Statistics	M
Jurela, Gabrijela	Assistant Representative	UNFPA BiH	F
Jurešić, Miroslav	Assistant Minister	Federal Ministry of Labour and Social Policy	M
Komić, Jasmin	Director	Republika Srpska Statistics Institute	M
Kremić, Emir	Director	Institute for Statistics of the Federation of Bosnia and Herzegovina	M
Kulenović, Jan Zlatan	Executive Director	Munja Social Innovation Incubator	M
Latinović, Milan	Head of Department	Ministry of Health and Social Welfare of Republika Srpska	M
Letić, Aleksandra	Program Manager	Helsinki Committee for Human Rights	F

Dr Lolić, Amela	Assistant Minister	Ministry of Health and Social Welfare of Republika Srpska	F
Makota, Dika	Director	Institute for Education, Bosnian-Podrinje Canton	F
Dr Maličbegović, Draženka	Assistant Minister	Ministry of Civil Affairs of Bosnia and Herzegovina	F
Marković, Saša	Director	Youth Communication Centre OKC Banja Luka	M
Mehić, Adisa	Head of Legal Affairs Department	Federal Ministry of Health	F
Dr Milovanović, Marina	Senior Expert	Ministry of Health and Social Welfare of Republika Srpska	F
Narayan, Geeta	Representative in BiH	UNICEF	F
Nastovska, Biljana	GBViE Specialist	UNFPA BiH	F
Dr Novo, Ahmed	Director	Agency for Healthcare Quality and Accreditation of the Federation of Bosnia and Herzegovina	M
Dr Olsavszky, Victor	Head of Country Office	WHO	M
Osmanagić, Emina	Director	XY	F
Pejović, Dalibor	Head of Department	Ministry of Civil Affairs of Bosnia and Herzegovina	M
Samardžić, Jasna	Head of Department	Bosnia and Herzegovina Agency for Statistics	F
Šarenkapić, Samid	CRSV Project Officer	UNFPA BiH	M
Saunders, David	Representative in BiH	UN WOMEN	M
Sinanoglu, Sezin	UN Resident Coordinator	UN/UNDP BiH	F
Smailbegović, Majda	Communication Assistant	UNFPA	F
Dr Šindrak, Ives	Gynaecologist	Primary Health Care Center Banja Luka	F
Sladojević, Branka	Head of Department	Ministry of Health and Social Welfare of Republika Srpska	F
Smajić, Minka	Assistant Minister	Ministry of Human Rights and Refugees of Bosnia and Herzegovina	F
Dr Stojisavljević, Stela	Specialist in Social Medicine	Public Health Institute of Republika Srpska	F
Dr Štrbac, Savka	Director	Republika Srpska Agency for Certification, Accreditation and Health Care Quality Enhancement	F
Tanović, Dalida	Project Manager	UK Foreign & Commonwealth Office	F
Van der Auweraert, Peter	Sub-Regional Coordinator for Western Balkans	IOM	M
Vidović, Gordana	Director	NGO Budućnost Modriča	F
Vlaić, Ivana	Coordinator	Bosnia and Herzegovina Football Federation	F
Vučković, Katarina	Project Coordinator	Institute for Youth Development KULT	F

Total: 57 (37 F, 20 M)

Annex 3 List of documents consulted

Strategic Planning Documents

- The UNFPA Strategic Plan 2008-2013
- The UNFPA Strategic Plan 2014-2017
- The UNFPA Strategic Plan 2018-2021
- One United Nations Programme and Common Budgetary Framework Bosnia and Herzegovina 2015-2019: United Nations Development Assistance Framework
- UNFPA Country Programme Document for Bosnia and Herzegovina 2010-2014
- UNFPA Country programme document for Bosnia and Herzegovina 2015-2019

Work Plans

- UNFPA Annual Work Plan 2013
- NGO Association XY Work Plan 2013
- UNFPA Annual Work Plan 2014
- UNFPA Annual Work Plan 2015
- One UN Programme Bosnia and Herzegovina 2015-2019 Joint Work Plan for the Years 2015-2016; Rule of Law and Human Security (Pillar 1)
- One UN Programme Bosnia and Herzegovina 2015-2019 Joint Work Plan for the Years 2015-2016; Sustainable and Equitable Development and Employment (Pillar 2)
- One UN Programme Bosnia and Herzegovina 2015-2019 Joint Work Plan for the Years 2015-2016; Social Inclusion: Education, Social Protection, Child Protection and Health (Pillar 3)
- One UN Programme Bosnia and Herzegovina 2015-2019 Joint Work Plan for the Years 2015-2016; Empowerment of Women (Pillar 4)
- NGO Buducnost Modrica Annual Work Plan 2015
- NGO Institute for Youth development KULT Annual Work Plan 2015
- NGO Youth Communication Centre OKC Annual Work Plan 2015
- NGO Partnership for Public Health Annual Work Plan 2015
- NGO Zena BiH Annual Work Plan 2015
- UNFPA Annual Work Plan 2016
- NGO Association XY Annual Work Plan 2016
- NGO Partnership for Public Health Annual Work Plan 2016
- UNFPA Annual Work Plan 2017
- One UN Programme Bosnia and Herzegovina 2015-2019 2017-2018 Joint UN Work Plan; Rule of Law and Human Security (Pillar 1)
- One UN Programme Bosnia and Herzegovina 2015-2019 2017-2018 Joint UN Work Plan; Sustainable and Equitable Development and Employment (Pillar 2)
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- One UN Programme Bosnia and Herzegovina 2015-2019 2017-2018 Joint UN Work Plan; Empowerment of Women (Pillar 4)
- NGO Association XY Annual Work Plan 2017
- NGO Partnerships for Public Health Annual Work Plan 2017
- NGO Interreligious Council Annual Work Plan 2017
- UNFPA Annual Work Plan 2018
- NGO Association XY Annual Work Plan 2018

- NGO Partnership for Public Health Annual Work Plan 2018

UNFPA BiH Other Planning Documents

- UNFPA BiH Comprehensive Sexuality Education Advocacy and Communication Action Plan 2015-2017
- UNFPA BiH Family Planning Advocacy and Communication Action Plan 2015-2017
- UNFPA BiH Population Policies and Healthy Ageing Advocacy and Communication Action Plan 2015-2017
- UNFPA BiH Partnership Plan 2015-2019, June 2016
- UNFPA BiH Partnership Plan 2015-2019, revised April 2017
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- UNFPA Country Programme 2015-2019 Resource Mobilisation Strategy, June 2015
- UNFPA Country Programme 2015-2019 Resource Mobilisation Strategy, revised April 2016
- UNFPA Country Programme 2015-2019 Resource Mobilisation Strategy, revised April 2017
- UNFPA Country Programme 2015-2019 Resource Mobilisation Strategy, revised April 2018

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- One United Nations Programme and Common Budgetary Framework Bosnia and Herzegovina 2015-2019: 2015 UN Country Results Report, March 2016
- One United Nations Programme and Common Budgetary Framework Bosnia and Herzegovina 2015-2019: 2016 UN Country Results Report (encompassing 2015 and 2016 delivery), March 2017
- One United Nations Programme and Common Budgetary Framework Bosnia and Herzegovina 2015-2019: 2017 UN Country Results Report, April 2017
- UNFPA BiH Country Office Annual Report 2013
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- Monitoring and Evaluation Results Group Brief, September 3, 2018
- Options for enhancing youth engagement in the BiH UN Youth Task Force developed in line with the principles of co-management, by Yael Ohana for UNFPA
- One UN Programme Bosnia and Herzegovina 2015-2019: UN Youth Task Force BiH: Proposal for Strategy and Programming with a view to developing a UNCT common approach to Youth issues, and developing a Joint UN Programme on Youth. Prepared by Yael Ohana. Commissioned by UNFPA CO Bosnia and Herzegovina

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- Partnership in Public Health Annual Workplan Progress Report Q2 2016, July 14, 2016
- Partnership in Public Health Annual Workplan Progress Report Q3 2016, October 12, 2016
- Partnership in Public Health Annual Workplan Progress Report 2016, January 14, 2017
- Meeting with Partnership in Public Health – Annual Review of Activities, January 26, 2017
- Partnership in Public Health Annual Workplan Progress Report Q1 2017, April 12, 2017

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- Partnership in Public Health Annual Workplan Progress Report Q3 2017, October 9, 2017
- Partnership in Public Health Annual Workplan Progress Report Q4 2017, January 16, 2018
- Meeting with Partnership in Public Health – Annual Review of Activities, January 29, 2018
- Association XY Annual Workplan Progress Report 2016, July 14, 2016
- Association XY Workplan Progress Report Q1 2018, April 12, 2018
- Association XY Workplan Progress Report Q2 2018, July 9, 2018
- Association XY Workplan Progress Report Q3 2018, October 10, 2018
- Association XY Workplan Progress Report Q4 2018, January 16, 2019

Donor Reports

- Joint project “Seeking Care, Support and Justice for Survivors of Conflict Related Sexual Violence in Bosnia and Herzegovina – Phase II” Quarterly Project Progress Report from Implementer to Post, April-June 2015
- Joint project “Seeking Care, Support and Justice for Survivors of Conflict Related Sexual Violence in Bosnia and Herzegovina – Phase II” Quarterly Project Progress Report from Implementer to Post, July-September 2015
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- Joint project “Seeking Care, Support and Justice for Survivors of Conflict Related Sexual Violence in Bosnia and Herzegovina – Phase IV” Quarterly Project Progress Report from Implementer to Post, June-October 2017
- Joint project “Seeking Care, Support and Justice for Survivors of Conflict Related Sexual Violence in Bosnia and Herzegovina – Phase IV” Quarterly Project Progress Report from Implementer to Post, October-December 2017
- Joint project “Seeking Care, Support and Justice for Survivors of Conflict Related Sexual Violence in Bosnia and Herzegovina” MPTF Office General Annual Programme Narrative Progress Report, September 2015-August 2017
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- Joint project “Seeking Care, Support and Justice for Survivors of Conflict Related Sexual Violence in Bosnia and Herzegovina” Project Completion Report March 2018
- Joint project “Seeking Care, Support and Justice for Survivors of Conflict Related Sexual Violence in Bosnia and Herzegovina UN ACTION MPTF Project Annual Report February 9, 2018
- “MISP Trainings for Sexual and Reproductive Health in Emergencies for Bosnia and Herzegovina Project” Swiss Agency for Development and Cooperation Final Report, March 2017
- “Policy Development on Ageing in Bosnia and Herzegovina Project” Swiss Agency for Development and Cooperation Final Report, October 2017”

- Association XY Annual Report 2018, January 16, 2019

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- UNFPA BiH Project Monitoring Report 2013 (system-generated October 23, 2018)
- UNFPA BiH Project Monitoring Report 2014 (system-generated October 23, 2018)
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- UNFPA BiH Project Monitoring Report 2017 (system-generated October 23, 2018)
- UNFPA BiH Project Monitoring Report 2013 (system-generated January 7, 2019)

Annex 4 Evaluation Matrix

COMPONENT 1: ANALYSIS BY FOUR FOCUS AREAS (Reproductive Health and Rights (RHR), Youth, Gender Equality (GE), Population and Development (PD))			
RELEVANCE (APPLIES TO ALL FOCUS AREAS)			
EQ1. To what extent is the UNFPA programme (i) adapted to the needs of women, adolescents and youth, people at risk of HIV infections, disabled and older persons, and Roma, (ii) and in line with the priorities set by the international and national policy frameworks, (iii) aligned with the UNFPA policies and strategies and the UNDAF (or equivalent document) as well as with interventions of other development partners? Do planned interventions adequately reflect the goals stated in the UNFPA Strategic Plan?			
<i>EQ1.A To what extent is the UNFPA programme adapted to the needs of women, adolescents and youth, people at risk of HIV infections, disabled, older persons and Roma?</i>			
Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ1.A Assumption 1: The evolving needs of women, adolescents and youth, people at risk of HIV infections, disabled and older person and Roma, were taken into account in programme design (both CPD and Annual Planning) and implementation (e.g. targeting/selection of beneficiaries).</u>	<ol style="list-style-type: none"> 1. Evidence of thorough needs assessments, studies, and secondary data analysis used in CP design. 2. The choice of target groups for UNFPA supported interventions is consistent with identified and evolving needs of marginalized populations. 3. Training designs have a focus on marginalized populations. 	<ol style="list-style-type: none"> 1.1 UNFPA needs assessment documents 1.2 UNCT common country assessment (CCA) 1.3 Available survey report e.g. Census, DHS, MICS etc. 1.4 UNFPA, UNCT and IP staff 2.1. Country Programme Document (CPD) 2.2. UNFPA Annual Plan 2.3. UNFPA and IP work plan and agreement 2.4. UNFPA and IP staff 3.1 UNFPA training reports 3.2 UNFPA and IP workplans 3.3 Staff interviews 	<ol style="list-style-type: none"> 1.1 Document review 1.2 Staff interviews 2.1 Document review 2.2 UNFPA and IP staff interview 3.1 Document review 3.2 Staff interview 3.3 Beneficiary interview
EQ1.A Assumption 1: Findings including analysis for all pertinent program areas: 1. Sexual and Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD.			
SRHR The CPDs 2010-2014 and 2015-2019(2020) prioritize the outcomes related to Reproductive Health and Rights with varying focus on specific target groups. While the CPD 2010-2014 focuses on health, health education and family planning policies and services that are inclusive of older persons, women, youth, and people at risk of			

HIV infections, as well as socially excluded sub-groups of some of these populations (youth and women), the CPD 2015-2019(2020) places additional focus on increased availability and use of integrated sexual and reproductive health services for Roma, among other vulnerable populations. The selection of target groups is generally in line with findings of the 2013 CCA, which identifies the following groups as the most vulnerable: persons with disabilities, returnees, displaced persons, Roma, families with two or more children, women, especially female heads of households, older persons, the unemployed and low-skilled youth, particularly in rural and semi-urban areas. UNFPA CO commissioned several needs assessments in the area of SRHR, including a report on the Implementation of Breast and Cervical Cancer Screening Programs in Bosnia and Herzegovina (August 2013) and Recommendations regarding Reproductive Health and Family Planning Training in Bosnia and Herzegovina (October 2013). However, apart from the evident focus on women in the report on breast and cervical cancer screening, neither of the two exemplary documents dedicate specific attention to other groups and sub-groups of population, including vulnerable and marginalized categories. Information from the latest MICS (2011-2012) and the MICS on Roma (2011-2012), which were published in 2013, was used as evidence in the CPD 2014-2019 (quote item 7.), while the CPD 2010-2014 generally lacked this evidence base. The evidence base concerning maternal mortality, contraceptive prevalence rate, the unmet need for family planning, and women's health proves relevance of UNFPA interventions under the outcome concerning Reproductive Health and Rights. However, a comprehensive DHS has not been conducted, which considerably limited the availability of evidence base for programming interventions in line with needs of specific demographic groups. Considering the views of stakeholders who are familiar with this intervention area, the partners in delivery of activities believe that UNFPA programme is generally well adapted to the needs of specific target groups, particularly women. However, there are also those who believe that persons with disability, youth, people at risk of HIV infection, and Roma have been largely neglected in this area of intervention. It was stressed by some stakeholders that UNFPA's business model is intended to build systems and capacities of these systems to be able to respond to everyone's needs in the health sector. This was particularly reflected in trainings developed and delivered to family medicine doctors, which approached the topic of Family Planning Repositioning generally, without specific focus on implications for individual categories of population, although the needs assessment preceding this intervention had noted the importance of "access of the entire population, including vulnerable groups, to quality SRH/FP services and contraceptives" (Recommendations, p. 18).

YOUTH Youth feature in the CPD 2010-2014 as one of the target groups under the outcome related to SRHR, which focuses on health, health education and family planning policies and services that are inclusive of older persons, women, youth, and people at risk of HIV infections, as well as socially excluded sub-groups of some of these populations (youth and women). The CPD 2015-2019(2020), however, singles out a specific component focusing on youth and adolescents. The emphasis on youth in CPD 2010-2014 is placed because of evidence of social exclusion, as cited in this document [item 6], but also because of lessons learned from the past, mostly regarding sexual education (non-existent in schools at the time, but good peer education initiatives had been noted [item 11]). However, this CPD does not make specific reference to different categories of youth population to mainstream the human rights and gender equality approach, e.g. by integrating girls, Roma, youth with disabilities. However, the 2013 CCA found that "further efforts should be made to support life-skills based education, including information on sexuality, reproduction and safe sexual practices, as well as entrepreneurial learning for adolescents and youth. In addition, the UN can support better involvement of young people in policy dialogue and decision-making. Future efforts may also consider supporting BiH authorities and civil society to implement specific behaviour changing activities targeting out-of-school youth, with a focus on Roma and other at-risk population groups" [p. 45] This view has been taken into account in CPD 2015-2019(2020), which finds that there are no coherent youth policies and strategies, that youth face high unemployment (particularly rural youth, Roma, youth with poor schooling or disabilities), that young Roma tend to marry very early, even before the age of 15, that one in three Roma girls give birth before the age of 15. It was also noted that youth and adolescents have poor knowledge about SRH and that comprehensive sexuality education was not available across the country. MICS data for general youth knowledge of SRH and access to SRH services was not quoted in this CPD. At least two sources analysing the needs of youth could have been referenced, including the 2012 Voices of Youth in BiH commissioned by UN's YERP (in which UNFPA participated) and Towards a Youth Policy in FBiH - Survey on the Position and Needs of Youth in the Federation of BiH in 2013. Interviews with stakeholders who are familiar with this programme area suggested that the programme was largely aligned with the needs to youth and adolescents, although no one singled out alignment

with different categories of youth population, particularly those furtherst behind. Some stakeholders commented that UN agencies in general have not worked out how to approach the Roma issue, including Roma youth.

GE The CPDs 2010-2014 and 2015-2019(2020) prioritize the outcomes related to Gender Equality focusing on two key groups of population - women and men, largely in the context of gender-based violence (GBV). It is evident from the CP (AWPs and COARs) that the key target group are women, who are victims of GBV and conflict-related sexual violence (CRSV). One subgroup of male population (boys) is mentioned in CPD 2015-2019(2020), which is reflected in COARs, relating to civil society initiatives involving men and boys in addressing GBV. Other initiatives involving and targeting youth are evident from COARs, e.g. youth theatre plays for reducing stigmatization of vicims of conflict-related sexual violence (CRSV), modules on role of youth in protection from GBV. Stakeholder interviews have confirmed, however, that the CP interventions have largely focused on women, particularly victims of GBV and CRSV, as target groups. This is in line with findings of the 2013 CCA stating that “Violence against women, especially domestic violence, continues to be a widespread social problem in BiH, and is a serious violation of the fundamental human rights of victims/survivors.” In line with this, CCA ranked Violence (Domestic Violence, Sexual/Gender Based Violence, Violence against Children, etc. the 13th among Top 15 Development Areas in BiH. Also, UNFPA supported the first Study on Prevalence and Characteristic of Violence against Women in BiH” from 2013, which suggested that almost half of women in Bosnia and Herzegovina older than 15 have been subjected at least once in their lifetime to some kind of violence (physical, psychological, sexual or economic) and one in ten has experienced violence in the past year. This study was quoted in CCA, and there is indication that it has been used in CPD 2015-2019(2020), although without specific reference. CPDs generally lack the evidence base for CRSV, except noting that “the legacy of physical and sexual abuse during the war, especially against women, still needs to be addressed.”

UNFPA CO has commissioned several researches to inform its planning to address GBV/CRSV as part of Joint Programme with other agencies. These included Research on stigma against CRSV survivors; Survey on perceptions, attitudes and opinions of medical and social services professionals towards GBV and CRSV issues and survivors; Research on masculinities and gender based violence against women in BiH; and Mapping of media reporting on CRSV. These studies informed UNFPA CP, which was directed toward enhancing health system’s response to needs of victims of GBV/CRSV, alleviating stigma, and gender transformative actions, largely through capacity building and advocacy.

PD The CPDs 2010-2014 and 2015-2019(2020) analyse and take into account the position of different categories of population with a view to plan support for development of population policies in BiH. The CPD 2010-2014 was developed prior to release of 2013 census data, but relies on the Labour Force Survey and other statistical sources to conclude that there has been substantial internal and external migration, that the fertility rate is low and that the country has an ageing population. This CPD also notes that social exclusion is a problem and defines vulnerable groups (older persons, people with disabilities, displaced persons, unemployed people, migrants and minorities, including Roma). The CPD 2015-2019(2020) uses the preliminary 2013 census data, noting a decreased population, as well as negative population growth due to declining birth rates, increasing mortality rates and continued migration. This CPD indicates that relavant population policies are not in place, including the policies for youth and older persons. For these reasons, the planned outputs under PD component in CPD 2010-2014 focus on socially excluded (including older persons) and migrant populations (youth targetted under YERP). The focus on older persons as a target group is upheld in CPD 2015-2019(2020), along with continued focus on building governmental capacities to creat evidence-based population policies based on emerging population issues (low fertility, ageing and migration). The analysis in CPDs is supported by 2013 CCA, which notes “At the State level, there are no coherent policies to address the low fertility rate, ageing and migration. Some family friendly policies are in place in the RS, as a reaction to negative population growth starting in 2002, while the FBiH has not developed such policies as of the date of the publication of this report, despite its entering of the stages of negative population growth in 2010.” Also, CCA noted that “Comprehensive migration database and evidence-based policies are lacking at State and Entity levels”. For this reason CCA recommends “To address these challenges, the UN should work closely with the BiH authorities to step-up efforts in strengthening

the government capacity at State, Entity and local levels for population data collection, analysis, dissemination and use, including for census and migration data. The collective UN efforts should also provide assistance in facilitating development and implementation of evidence-based population policies in line with demographic trends, with full respect for gender and human rights, and integrated in the broader development process”. This finding is confirmed in UNFPA programming in BiH.

There is evidence in AWP, COARSS and from stakeholder interviews that the CP has focused on two targets group under the PD component over the years, which are the migrants and older persons. The focus on migrants has been placed as part of implementation of YERP and establishment of migration software with the BiH Ministry of Security, and this work features in the CP in 2013 and 2014 of the evaluation period. The focus on older persons has been continuous throughout two CPs. Even though the work related to migration had stopped after 2014, stakeholders have confirmed a continued need for evidence base in the area of migration for development of sound policies. Monitoring of migrations has also been an explicit prerequisite for BiH’s rapprochement with the EU in the accession process. It was observed through stakeholder interviews that although YERP had been a project targeting youth specifically, UNFPA’s activities on establishment of migration database in the BiH Ministry of Security were comprehensive and intended to build monitoring systems for all migrants. Stakeholders have also confirmed the importance of working on issues of older persons, as very little, or no attention has been paid to this group of population through other domestic or international initiatives. The status and needs of older persons have been identified as part of the work on Strategies for Improving the Status of Older Persons in FBiH and RS, but also earlier, in 2013 and 2014 while UNFPA was developing a National Social Policy on Older Persons with the BiH Ministry of Human Rights and Refugees. It is unknown to what extent the planning of work in relation to older persons under CP was informed by the Ombudsman’s report on the state of human rights of older persons (http://www.diskriminacija.ba/sites/default/files/node_file_upload/obmudsmen_doc2013020406211683bos1.pdf), but this document does identify a lack of strategic approach to the status and needs of older persons and the interviewed institutions from both entities stress the need for adoption of relevant strategies.

EQ1.B To what extent is the UNFPA programme in line with the priorities set by the international and national policy frameworks?

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ1.B Assumption 1: The evolving priorities set by the international and national policy frameworks were taken into account in UNFPA programme design (both CPD and Annual Planning) and implementation (e.g. targeting/selection of beneficiaries)</u>	1. Correlation of UNFPA program priorities with priorities set by UNFPA Strategic Plan and national policy frameworks.	1.1 UNFPA programme documents 1.2 UNFPA Strategic Plan and national policy frameworks. 1.3 UNFPA and IP staff	1.1 Document review 1.2 Staff interviews

EQ1.B Assumption 1: Findings including analysis for all pertinent program areas: 1. Sexual and Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD.

SRHR UNFPA’s strategic goal globally has remained the same over two strategic planning cycles (2014-2017, 2018-2021): “achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the agenda of the Programme of Action of the International Conference on Population and Development, to improve the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality”. UNFPA CPDs for BiH reflect clearly this goal, translating it into individual outcomes and outputs related to Reproductive Health and Rights. The interventions planned in AWP are in line with this international framework, focusing on strengthening institutional capacities and policies for ensuring integrated sexual and reproductive health services, with intention to extend to youth friendly services, and improving maternal health and reducing maternal deaths. When it comes to alignment with domestic policy frameworks, the CPD 2010-2014 quoted the Social Inclusion Strategy (2008-2013), while the subsequent CPD quoted “the 2012 national policy on sexual and reproductive

health” under the SRHR outcome. It should be noted that RS had adopted the SRH Policy in 2013 for the period 2012-2017 and FBiH had adopted its SRH Strategy in 2010 for the period 2010-2019. Stakeholders from governments have confirmed in interviews that UNFPA CO has always engaged in a thorough consultation and planning process with them in order to ensure that the proposed interventions match domestic policies and priorities. For example, official figures in BiH suggest that this country does not have maternal mortality issues that are comparable to some other countries, as quoted in UNFPA Strategic Plan 2014-2017 (“800 women still die every day from childbirth and the complications of pregnancy”). For this reason, the intervention Beyond the Numbers, which was initially envisaged by the UNFPA in BiH, was replaced, in consultation with domestic partners, by an intervention which is intended to pilot an obstetric surveillance system based on near-miss cases, in order to suit more the context of BiH.

YOUTH According to the UNFPA Strategic plan 2014-2017, “Women, adolescents and youth are the key beneficiaries of UNFPA work”. The desired outcome from this plan in relation to youth is “Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health services” and this outcome has been quoted as reference in the UNFPA BIH CPD 2015-2019(2020). UNFPA Strategic Plan 2014-2017 defines three ways to achieve this outcome: 1. strengthening the capacity of institutions to conduct data analysis related to adolescents and youth so that their specific SRH needs can be incorporated into national laws, policies, and programmes, 2. ensuring there is comprehensive sexuality education curricula and its meet international, 3. addressing the innovative adolescent girls initiative that UNFPA is launching on child marriage to reach at-risk girls. Three desired outcomes of UNFPA Strategic Plan 2018-2021 target youth and adolescents, including girls [see section above] (Outcome 1. Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised, Outcome 2. Every adolescent and youth, in particular adolescent girls, is empowered to have access to sexual and reproductive health and reproductive rights, in all contexts reproductive rights, free of coercion, discrimination and violence, Outcome 3. Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings). The CPD 2015-2019(2020) reflects these priorities. Evidence of specific and relevant interventions was found in AWP’s and COAR’s, for example support to drafting of youth policies in RS and FBiH, working to introduce comprehensive sexual education along with youth friendly SRH services under SRHR component, initiatives to prevent early marriages among Roma, and attempts at joint work of UN agencies in BiH on youth issues.

When it comes to alignment with domestic policy frameworks, the CPD 2010-2014 quoted the Social Inclusion Strategy (2008-2013), while the subsequent CPD said that “coherent youth policies and strategies are not in place.” The CPDs do not make reference to at least two youth policies that have been in force in RS covering the periods 2006–2010, 2010–2015 and matching the periods of UNFPA country programming. Also, there is no reference to the RS SRH Policy for the period 2012-2017 and FBiH SRH Strategy for the period 2010-2019, or cited assessment of how these policies make UNFPA’s Youth programme area relevant. CPDs do not cite the Roma Strategy 2005-2015 and Action Plans (2013-2016, 2017-2020) [relevant also for SRHR]. Stakeholders interviewed have generally confirmed relevance of this programme area in relation to local needs, recognizing lack of relevant domestic policies in some jurisdictions within the country and noting that domestic policy priorities do not always reflect the real needs of different groups of population.

GE UNFPA’s strategic goal globally has remained the same over two strategic planning cycles (2014-2017, 2018-2021): “achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the agenda of the Programme of Action of the International Conference on Population and Development, to improve the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality”. The Outcome 3 from the Strategic Plan 2014-2017 plans for “Advanced gender equality, women’s and girls’ empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth”. Under this outcome, UNFPA’s outputs pertain to the systems that monitor compliance with human rights obligations and recommendations with regard to violations of reproductive rights, integration of GBV programming into broader SRH services, including in the context of humanitarian

programming, and integrating civil society and faith-based organizations role in promoting reproductive rights and gender equality. Under Outcome 3 of the Strategic Plan 2018-2021 “Gender equality, the empowerment of all women and girls, and Reproductive Rights are advanced in development and humanitarian settings”, UNFPA’s envisaged outputs relate to addressing gender-based violence for advancing gender equality and the empowerment of women and girls. UNFPA interventions on gender-based violence focus on advocacy, data, health and health systems, psychosocial support and coordination, including increasing multisectoral capacity and using a continuum approach in development and humanitarian settings.

UNFPA CPDs for BiH reflect clearly the goals, outcomes and outputs from UNFPA Strategic Plans. However, the focus varies to some extent. While the CPD 2010-2014 focuses on the outcome “Security sector and law enforcement sector agencies integrate gender equality issues and mainstream gender into their policies and protocols, including those on gender-based violence”, the CPD 2015-2019(2020) defines the pertinent outcome as “Advanced gender equality, women’s and girls’ empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth”. The CP outputs vary accordingly over the years of CPD implementation, with the emphasis moving from interventions in the security sector to those in the health sector and civil society. It was observed that certain interventions under GE component of UNFPA CP, which feature highly in AWP and COARs, have not been planned either by the UNFPA Strategic Plans or CPDs (except in CPD 2015-2019/20), e.g. the work on stigma and work with perpetrators. According to stakeholders, these activities have been included in the CP because of the local context, evidenced through assessments, and they are not covered by UNFPA core funding, but CPD 2015-2019 says “advocating for a conducive human rights environment for empowerment of survivors of gender-based and conflict-related sexual violence.”

In line with the nature of interventions, the alignment with international and national priorities has changed over years. The CPD 2010-2014 quotes the national small arms and light weapons strategy and “national law on disaster management and preparedness” in the GE component, as well as the United Nations Security Council resolution 1325 on women, peace and security, which calls for “the protection of women and girls from sexual and gender-based violence, including in emergency and humanitarian situations, such as in refugee camps” and “advancement of relief and recovery measures to address international crises through a gendered lens, including by respecting the civilian and humanitarian nature of refugee camps, and considering the needs of women and girls in the design of refugee camps and settlements” (apart from specific measures for the participation of women and prevention of violence against women https://www.usip.org/gender_peacebuilding/about_UNSCR_1325). The CPD 2015-2019(2020) refers to the Concluding Observations of the United Nations Committee on the Elimination of Discrimination against Women. In terms of national policies, this CPD, as well as the previous one, fails to refer to the Gender Equality Law, the Gender Action Plans, or the strategies for prevention of violence against women, including UNFPA’s previous efforts to draft and advocate the Programme for Improvement of Status of Women Victims of Conflict Related Sexual Violence and Torture in BiH (<https://ba.unfpa.org/sites/default/files/pub-pdf/bosanski01.pdf>). However, this does not necessarily mean that these international and national policies have not been taken into account in delivery of interventions. Namely, it is reported by UNFPA that in the joint programming for Seeking Care, Support and Justice for Survivors of Conflict Related Sexual Violence in BiH, the priorities from CEDAW, UNSCR 1325 Action Plan for BiH and GAP BiH have been taken into account. Stakeholders have confirmed that delivery of interventions in the area of establishment of referral mechanisms have contributed to implementing of obligations under BiH’s Framework Strategy for implementing the Istanbul Convention.

PD UNFPA’s strategic goal globally has remained the same over two strategic planning cycles (2014-2017, 2018-2021): “achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the agenda of the Programme of Action of the International Conference on Population and Development, to improve the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality”. UNFPA CPDs for BiH reflect clearly this goal in relation to population dynamics and the need for creating evidence-based population policies. This is defined in the CPD 2010-2014 outcome for this component “The Government, at all levels, is able to base policies on a quantitative and qualitative analysis of disaggregated data, policy assessments and

reviews, with attention focused on socially excluded groups and migrant populations” and in CPD 2015-2019(2020) “Strengthened national policies and international development agenda through integration of evidence-based analysis of population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality.” The UNFPA Strategic Plans provide further guidance on how population dynamics should be monitored and used as evidence base, that is, by taking into account “the growth or decline of a population from high or low fertility, shifts in age structures, urbanization, and migration” (2014-2017), and also by shifting focus from historical data production from censuses, surveys and other similar statistical sources to “non-traditional data in order to fill gaps” (2018-2021). Both programme cycles of UNFPA in BiH demonstrated efforts to integrate these strategic priorities in its interventions. This included activities on improvement of migration statistics, conducting of survey of prevalence of violence against women, supporting the census activities (the latter two prior the evaluation period), collecting and analysis of census data for advocacy, mobilization for localization of SDGs, mobilization for MICS6 and DHS, as well as activities on ensuring population situation analysis and population projections and SRH mapping. In the CPD 2010-2014, several national priorities are quoted as relevant to this area of intervention: national development strategy, social inclusion strategies, and European Partnership and European Union Integration Strategy. National policies are not quoted in CPD 2015-2019(2020). Documentary search and stakeholder interviews have confirmed that BiH does not avail itself of population policies, while development policies exist. For example, the Strategic Framework for BiH from 2015 (<http://www.dep.gov.ba/naslovna/DEP%20Strateski%20okvir%20za%20BiH.pdf>) does examine the status of population and population dynamics under the Chapters Reducing Poverty and Social Exclusion, and Improving Health Care, and identifies a set of measures under the following priorities: To improve the system for protection of human rights and development of BiH relations with diaspora, Efficient coordination in social protection and pension areas, and Improving coordination in the health sector.

However, one part of CP, related to work on Strategies for Improvement of Status of Older Persons and support to Healthy Ageing Centres, does not seem to reflect the UNFPA Strategic Plans, including the current one for 2018-2021. Older persons do not feature as a target group in these plans, but the CPD 2010-2014 plans the output “Officials of the Directorate for Economic Planning have the knowledge and skills to implement the Madrid International Plan of Action on Ageing through the European regional implementation strategy and through strategies for older persons”, while the CPD 2015-2019(2020) envisages to “help the Government and civil society to formulate comprehensive programmes, in line with the Madrid International Plan of Action on Aging, and promote intergenerational solidarity.” The CP interventions in this area reflect alignment with this international policy framework. Also, despite elaborate legislation on health and social protection in individual jurisdictions in BiH, older persons do not feature as specific target group in any policy. For this reason, the drafting of Strategies for Improvement of Status of Older Persons in the two entities has been considered by all stakeholders as very relevant intervention and in line with the domestic context.

EQ1.C To what extent is the UNFPA programme aligned with the UNFPA policies and strategies and the UNDAF (or equivalent document) as well as with interventions of other development partners?

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ1.C Assumption 1: There is evidence of alignment between the UNFPA programme and a) UNFPA policies and strategies, b) the UNDAF (or equivalent document) and c) interventions of other development partners.</u>	<ol style="list-style-type: none"> The objectives and strategies of the CP and the AWP are in line with the goals and priorities set in the UNDAF or equivalent document ICPD goals are reflected in the CP and component activities 	<ol style="list-style-type: none"> UNFPA programme documents (CPD, AWP, COAR etc.) UNFPA Strategic Plan and Annexes UNDAF (or equivalent document), interventions of other development partners. UNFPA, UNCT and IP staff 	<ol style="list-style-type: none"> Document review Staff interviews

	<ol style="list-style-type: none"> 3. The CP sets out relevant goals, objectives and activities to develop national capacities 4. Evidence of mainstreaming South-South cooperation in the country programme 5. Evidence of mainstreaming gender equality and women’s empowerment 6. Evidence of human rights approach applied in programme design and implementation 		
<p>EQ1.C Assumption 1: Findings including analysis for all pertinent program areas: 1. Sexual and Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD.</p> <p>SRHR UNFPA programme is aligned with priorities set in UNDAF for the periods 2010-2014 and 2015-2019(2020). In both periods, UNFPA featured as a partner of other UN agencies in planning how to achieve several UNDAF priorities, including that of Social Inclusion and Human Security, for which UNFPA’s interventions in the area of SRHR are relevant. UNFPA has regularly participated in drafting of regular biannual joint work plans. In the area of health, UNFPA has committed to the following in the periods 2015-2016 and 2017-2018: development and implementation of evidence-based SRH guidelines, development of FP curriculum, establishing of BtN methodology for maternal death surveillance at pilot sites, and integrating elements of Minimum Initial Service Package for Reproductive Health in crisis into emergency preparedness plans. These are exactly the key targets from UNFPA’s CPD 2015-2019(2020) and relevant AWP.</p> <p>UNFPA CPDs do not quote the ICPD goals but they are reflected in the CP. In the area of SRHR, the interventions are clearly in line with the ICPD objectives related to reproductive health and reproductive rights (including in cases of emergencies), family planning, sexually transmitted diseases and prevention of human immunodeficiency virus (HIV), women’s health and safe motherhood.</p> <p>South-South cooperation does not feature in the CPD 2010-2014, but its promotion is planned in the CPD 2015-2019(2020). South-South and triangular cooperation features in the UNFPA Strategic Plan 2018-2021 as an additional mode of engagement in BiH as one of the “pink” countries, and this is a “platform to exchange know-how and support between the countries in need and those with deployable expertise” [p. 14-15]. Evidence of utilization of this platform in the CP has been found in the area of SRHR. More specifically, stakeholders from BiH participated in two inter-country workshops (eight countries and territories) on maternal mortality and morbidity surveillance in line with WHO “Beyond the Numbers” methodology, first in cooperation with the Regional Development Center on Public Health Services in the Republic of North Macedonia and then with the East European Institute for Reproductive Health in Romania [https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_PUB_2018_EN_SSTC_in_Action_-_Sexual_Reproductive_Health.pdf, p. 31].</p>			

Concerning application of human rights approach to CP design and implementation, both CPDs draw attention to marginalized groups in the area of SRHR. For example, in the CPD 2010-2014 identifies social exclusion as a problem and identified vulnerable groups, including older persons, people with disabilities, displaced persons, unemployed people, migrants and minorities, including Roma. However, the SRHR component, according to this CPD, largely targets older persons, women and youth, particularly socially excluded, for inclusion in health and health education policy making and service provision. Other marginalized groups are not included in this intended outcome. In the CPD 2015-2019(2020), the proposed programme claims applying a human rights-based approach in all interventions, including reliance on the principle of “access to affordable, integrated sexual and reproductive services that are high-quality and meet human rights standards”, eliminating all forms of discrimination and empowering of marginal groups, “with an emphasis on women, adolescents and youth (particularly girls)”. This CPD quotes recommendation from 2013 Evaluation of the CP that the focus on marginalized groups should increase. In line with the human rights-based approach, the CPD 2015-2019(2020) defines the one output in the area of SRHR as increasing capacities for delivery of integrated SRH services “with focus on Roma and vulnerable populations”, and delivering interventions with “focus on reducing inequities.”

The CPDs do not make specific reference to gender mainstreaming, but women’s rights feature highly in both documents in the area of SRHR as specific interventions are intended for inclusion of women in health and health education policies, relevant SRH service provision, and maternal health in general. Youth also feature highly as a target group in CPDs, while particular emphasis is placed on girls in the CPD 2015-2019(2020). However, in terms of gender equality, men are not defined as a specific target group.

YOUTH UNFPA programme is aligned with priorities set in UNDAF for the periods 2010-2014 and 2015-2019(2020). In both periods, UNFPA featured as a partner of other UN agencies in planning how to achieve several UNDAF priorities, including that of Social Inclusion, which is relevant for UNFPA’s interventions in the area of Youth and Adolescents. UNFPA has regularly participated in drafting of regular biannual joint work plans. In the areas of health and education, UNFPA has committed to the following in the periods 2015-2016 and 2017-2018: strengthening capacity and provision of support to relevant key stakeholders in development and implementation of CSE, and providing support to the relevant stakeholders in implementation of BiH Roma Action Plan. It should be noted that, although youth feature as one of target groups under the Social Inclusion outcome of UNDAF, some stakeholders said that this group of population deserved greater and specific attention in this partnership document.

UNFPA CPDs do not quote the ICPD goals but they are reflected in the CP. In the area of Youth and Adolescents, the interventions are clearly in line with the ICPD objectives related to children and youth, including youth participation in policy making, youth access to SRH services and education, and elimination of child marriages.

Evidence of utilization of South-South cooperation as a platform to exchange know-how between countries has not been found in the CP’s part related to Youth and Adolescents.

Concerning application of human rights approach to CP design and implementation, both CPDs draw attention to marginalized groups in the area of SRHR, while in the area of Youth and Adolescents the human rights of youth and adolescents are emphasized in the definition of key output. In the CPD 2010-2014, the SRHR component largely targets older persons, women and youth, particularly socially excluded, for inclusion in health and health education policy making and service provision. In the CPD 2015-2019(2020), the proposed programme claims applying a human rights-based approach in all interventions, including reliance on the principle of “access to affordable, integrated sexual and reproductive services that are high-quality and meet human rights standards”, eliminating all forms of discrimination and empowering of marginal groups, “with an emphasis on women, adolescents and youth (particularly girls)”. This CPD quotes recommendation from 2013 Evaluation of the CP that the focus on marginalized groups should increase. In line with the human rights-based approach, the CPD 2015-2019(2020) defines the one output in the area of Youth and Adolescents

as increasing national capacity to conduct evidence-based advocacy for incorporating the human rights and needs of adolescents and youth in national laws, policies, programmes, including in humanitarian settings. Specific gender mainstreaming actions are reflected in the defined approach to delivery of interventions, e.g. development and implementation of gender-sensitive sexual and reproductive health and rights-related strategies on youth, with focus on disadvantaged groups, and addressing early marriages and early onset of sexual life among Roma girls and boys, including Roma teen pregnancies.

GE UNFPA programme in the area of Gender Equality is aligned with priorities set in UNDAF for the periods 2010-2014 and 2015-2019(2020). In both periods, UNFPA featured as a partner of other UN agencies in planning how to achieve UNDAF priorities related to Human Security and Social Inclusion, for which UNFPA's interventions in the area of GE are relevant. In the UNDAF 2010-2014, the planned outcome for Social Inclusion "Outcome 2.3 Basic health and education, social protection and employment service providers are better able to ensure access to quality services for socially excluded and vulnerable groups, including marginalised rural poor" is pertinent to UNFPA in the area of Gender Equality, and for Human Security "Outcome 4.4. Security and law enforcement sector agencies integrate gender equality issues and mainstreams gender into its policies and protocols and take action to protect women against violence". In the UNDAF 2015-2019(2020), UNFPA, in cooperation with other UN agencies, pledged to contribute to achievement of outcomes 12 and 13 under Pillar 4 Empowerment of Women by 1. establishing coordination body/ies at different levels to monitor and implement the Istanbul Convention and UPR recommendations, including for reproductive health, 2. assessing available services for CRSV and gathering necessary data, through researches on masculinities, service assessments, CRSV stigma and perception, the strength of referral mechanisms (formal and informal ones linked to existing Free Legal Aid and Victim Witness Networks), compendium of actors in CRSV, 3. establishing a number of protocols for referrals within health and multi-sector service referrals in selected locations, including minimum standards for service provision in health for CRSV survivors in a selected locations, 4. engaging CSOs in psycho-social support to perpetrators of violence, including through provision of capacity building activities, partnership initiatives with governmental organizations and advocacy, 5. Reducing discrimination and stigma against CRSV survivors through innovative solutions and best practices in fighting stigma at societal and service providers' level, 6. Designing and implementing forum theatre plays on child protection issues, such as violence and child marriage, and where and how to seek support in all primary schools in 6 municipalities [from biannual plans].

UNFPA CPDs do not quote the ICPD goals in the area of GE, but they are reflected in the CP. In the area of GE, the interventions are clearly in line with the ICPD objectives related to Empowerment and status of women and Male participation and responsibility, including Eliminating all practices that discriminate against women; assisting women to establish and realize their rights, including those that relate to reproductive and sexual health and Eliminating violence against women.

South-South cooperation does not feature in the CPD 2010-2014, but its promotion is planned in the CPD 2015-2019(2020). There is no evidence of usage of this platform in the area of GE.

Concerning application of human rights approach to CP design and implementation, CPD 2010-2014 draws attention to gender-based discrimination in BiH, with three issues are of particular concern: (a) unequal representation of women in political processes; (b) access to employment; and (c) gender-based violence. The CPD 2015-2019(2020) notes persisting gender inequality and traditional gender roles, as well as widespread and unreported violence against women, and the legacy of physical and sexual abuse during war. CPD 2015-2019(2020) states that the programme will promote gender equality and empowerment of women by applying a human rights based approach and "advocating for a conducive human rights environment for empowerment of survivors of gender-based and conflict-related sexual violence". Also, UNFPA refers to the Universal Periodical Review for measuring the outcome indicator for this component in relation to implementation of recommendations on reproductive rights for BiH.

The CPDs do not make specific reference to gender mainstreaming as such, but women's rights feature highly in both documents in the area of GE. There is evidence of taking the role of male participation in ensuring gender equality in CPD 2015-2019(2020) through "introducing gender-transformative approaches and strengthening the capacity of civil society organizations to engage men and boys on gender equality and gender-based violence, including the legacy of conflict related sexual violence."

PD Under UNDAF 2010-2014 Outcome 1 Democratic Governance the specific Outcome 1.1 is planned: Government at all levels is able to base policies on quantitative and qualitative analysis of disaggregated data, policy assessments and reviews, with focused attention on socially excluded groups and migrant populations. This is related to work on evidence-based population policies. The work relating to older persons has been integrated under Social Inclusion outcome. UNDAF 2015-2019(2020) does not single out evidence-based policy making, but work relating to status of older persons is accounted for under Outcome 9 "By 2019, targeted legislation, policies, budget allocations and inclusive social protection systems are strengthened to pro-actively protect the vulnerable." Under this outcome, in the WP 2015-2016 both the work on policies for older persons (Validate social policy guidelines for ageing with entity responsible ministries, draft strategies for ageing at entities levels and establish centres for healthy ageing) and UNFPA's work on population data (Analyze secondary census data for ageing and gender aspects, analyze potential additional sources of data on migration and gender aspects of migration, and develop population situation analysis) is reflected under the Social Inclusion pillar. In WP (2017-2018) UNFPA's commitments are Develop draft strategies on ageing in Republika Srpska, Federation of BiH and Brcko District and promote centres for healthy ageing; and Conduct population situation analysis.

UNFPA CPDs do not quote the ICPD goals but they are reflected in the CP. In the area of PD, the interventions are clearly in line with the ICPD objectives related to Interrelationships between population, sustained economic growth and sustainable development, Population growth and structure (specifically in relation to fertility, mortality and population growth rates and older people), and International migrations.

The CP has set relevant goals in terms of outputs defined in CPDs in relation to evidence-based policy making (including work on migrations, etc) and ageing. Relevance is confirmed through international policy framework, and the national context and needs.

There is clear evidence of South-South cooperation in delivery of CP. UNFPA has facilitated cooperation between its IP PPH and the Ministry of Labour and Social Protection of the Republic of North Macedonia through a capacity building event where positive practices and experiences from BiH were conveyed to counterparts in the Republic of North Macedonia on establishment and management of Health Ageing Centre. As a result, it was reported that the Government of the Republic of North Macedonia was going to support opening of at least two such Centres

Concerning application of human rights approach to CP design and implementation, both CPDs draw attention to marginalized groups in the area of PD. For example, the CPD 2010-2014 identifies social exclusion as a problem and vulnerable groups, including older persons, people with disabilities, displaced persons, unemployed people, migrants and minorities, including Roma. However, the PD component, according to this CPD, targets migrants and socially excluded, including older persons. In the CPD 2015-2019, the proposed programme claims applying a human rights-based approach in all interventions, but with specific vision to "strengthen partnerships for the development of comprehensive rights-based and evidence-based population policies".

CPDs do not make specific reference to gender mainstreaming, although the work on data collection and analysis for evidence-based population policies include indicators for women and men. There is evidence of accounting for different implications of ageing for women and men in the Strategies for Improvement of Status of Older Persons.

<i>EQ1.D Do planned interventions adequately reflect the goals stated in the UNFPA Strategic Plan?</i>			
Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ1.D Assumption 1: The planned interventions adequately reflect the goals of the UNFPA Strategic Plan</u>	1. The objectives and strategies of the CP and the AWP are in line with the goals and priorities set in the UNFPA Strategic Plan and Annexes.	1.1 UNFPA programme documents (CPD, AWP, COAR etc.) 1.2 UNFPA Strategic Plan and Annexes 1.3 UNFPA, staff	1.1 Document review 1.2 Staff interviews
EQ1.D Assumption 1: Findings including analysis for all pertinent program areas: 1. Sexual and Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD.			
<p>SRHR The UNFPA Strategic Plans state the equal goal for two periods (2008-2013, 2014-2017) “achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the agenda of the Programme of Action of the International Conference on Population and Development, to improve the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality”. The strategic plans identify outcomes differently over two periods, but in the area of SRHR, the key expected outcome is “Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access”. This outcome has been translated into both CPDs with outputs related to SRH policy development with domestic institutions and building capacities of service providers. A review of the AWP has confirmed that the interventions have been planned in line with UNFPA’s global strategic goal. The specific interventions from AWP recognized as contributing directly to the strategic goals and outcomes are: support to development of SRH policies, contraception advocacy and family planning repositioning, recommendations for breast and cervical cancer screening, production of guidelines to improve maternal health, maternal death surveillance, and integration of MISP into emergency preparedness.</p> <p>YOUTH According to the UNFPA Strategic plan 2014-2017, “Women, adolescents and youth are the key beneficiaries of UNFPA work”. The desired outcome from this plan in relation to youth is “Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health services” and this outcome has been quoted as reference in the UNFPA BIH CPD 2015-2019(2020). UNFPA Strategic Plan 2014-2017 defines three ways to achieve this outcome: 1. strengthening the capacity of institutions to conduct data analysis related to adolescents and youth so that their specific SRH needs can be incorporated into national laws, policies, and programmes, 2. ensuring there is comprehensive sexuality education curricula and its meet international, 3. addressing the innovative adolescent girls initiative that UNFPA is launching on child marriage to reach at-risk girls. Three desired outcomes of UNFPA Strategic Plan 2018-2021 target youth and adolescents, including girls [see section above] (Outcome 1. Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised, Outcome 2. Every adolescent and youth, in particular adolescent girls, is empowered to have access to sexual and reproductive health and reproductive rights, in all contexts reproductive rights, free of coercion, discrimination and violence, Outcome 3. Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings). The CPD 2015-2019(2020) reflects these priorities. Evidence of specific and relevant interventions was found in AWP and COARs, for example support to drafting of youth policies in RS and FBIH, working to introduce comprehensive sexuality education along with youth friendly SRH services under SRHR component, initiatives to prevent early marriages among Roma, and attempts at joint work of UN agencies in BiH on youth issues.</p> <p>GE UNFPA’s strategic goal globally has remained the same over two strategic planning cycles (2014-2017, 2018-2021): “achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the agenda of the Programme of Action of the International Conference on</p>			

Population and Development, to improve the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality”. The Outcome 3 from the Strategic Plan 2014-2017 plans for “Advanced gender equality, women’s and girls’ empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth”. Under this outcome, UNFPA’s outputs pertain to the systems that monitor compliance with human rights obligations and recommendations with regard to violations of reproductive rights, integration of GBV programming into broader SRH services, including in the context of humanitarian programming, and integrating civil society and faith-based organizations role in promoting reproductive rights and gender equality. Under Outcome 3 of the Strategic Plan 2018-2021 “Gender equality, the empowerment of all women and girls, and reproductive Rights are advanced in development and humanitarian settings”, UNFPA’s envisaged outputs relate to addressing gender-based violence for advancing gender equality and the empowerment of women and girls. UNFPA interventions on gender-based violence focus on advocacy, data, health and health systems, psychosocial support and coordination, including increasing multisectoral capacity and using a continuum approach in development and humanitarian settings.

PD UNFPA’s strategic goal globally has remained the same over two strategic planning cycles (2014-2017, 2018-2021): “achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the agenda of the Programme of Action of the International Conference on Population and Development, to improve the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality”. UNFPA CPDs for BiH reflect clearly this goal in relation to population dynamics and the need for creating evidence-based population policies. This is defined in the CPD 2010-2014 outcome for this component “The Government, at all levels, is able to base policies on a quantitative and qualitative analysis of disaggregated data, policy assessments and reviews, with attention focused on socially excluded groups and migrant populations” and in CPD 2015-2019(2020) “Strengthened national policies and international development agenda through integration of evidence-based analysis of population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality.”

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

EQ2.A To what extent has the UNFPA office been able to respond to changes in the national development context?

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ2.A Assumption 1: The UNFPA office has a mechanism in place to facilitate responses to changes in the national development context.</u>	1. Evidence of a UNFPA mechanism to facilitate a response to changes in national development context.	1. UNFPA country program documents. 2. UNFPA and IP staff	1. Document review 2. Staff interviews.

EQ2.A Assumption 1: Findings including analysis for all pertinent program areas: 1. Sexual and Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD.

SRHR The biggest changes in the national development context occurred at times of specific crisis, most notably during the 2014 floods and 2018 migrant crisis. According to staff and stakeholder interviews, as well as COARs, UNFPA has been able to respond to these changes by mobilizing resources to address the country’s newly emerging needs. The interventions undertaken were in the area of Gender Equality under the CPD 2010-2014 and in the area of SRHR in the CPD 2015-2019(2020). Although the CPDs do not specifically make room for direct emergency response, building of capacities for protecting women in emergencies has been foreseen as specific intervention.

YOUTH In this area of intervention, there has been one major change in the domestic context, although not necessarily confirmed by evidence. This change is related to youth emigration. This was observed by UNFPA through population data and other sources monitoring, but this has not been mentioned directly in the CPD.

GE UNFPA has been able to adapt to different policy stances of different partners in BiH with regard to specific areas of intervention. For example, RS health authorities were not willing to single out health system’s response to victims of CRSV, but wanted to target this group through services for victims of GBV in general. UNFPA adapted its activities to this position.

PD Response to census results issues, UNFPA has adapted to the fact that entities and the state in BiH did not have the same views on the census results, as well as to separate RS census results.

EQ2.B To what extent has the UNFPA office been able to respond to an aggravated humanitarian situation in countries/territory, if such situation has existed?

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ2.B Assumption 1: UNFPA has provided a timely, appropriate and sufficient response to an aggravated humanitarian situation.</u>	1. Evidence of UNFPA response to an aggravated humanitarian situation.	1. UNFPA program documents (including annual work plans and annual reports). 2. UN and Government ministry documents. 3. UNFPA, IP and government staff	1. Document review 2. Staff interviews

EQ2.B Assumption 1: Findings including analysis for all pertinent program areas: 1. Sexual and Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD.

SRHR UNFPA is recognized among most stakeholders as an agency that responded appropriately and timely at the time of floods in BiH in 2014 and migrant crisis in 2018. The assistance during floods consisted of implementation of MISP, distribution of dignity kits, as part of MISP, and supply of medical vehicles to two clinics. According to stakeholders, UNFPA also reacted outstandingly during the migrant crisis by procurement of dignity kits, conducting a needs assessment for SRH/GBV, appointing a GBV specialist in the area affected the most by migrant crisis, establishing services for GBV victims, and helping local structures respond to crisis. [COAR, 2014, p. 31-2]

YOUTH FBIH resource pack contains youth in crisis.

GE UNFPA is recognized among most stakeholders as an agency that responded appropriately and timely at the time of floods in BiH in 2014 and migrant crisis in 2018. The assistance during floods consisted of implementation of MISP, distribution of dignity kits, as part of MISP, and supply of medical vehicles to two clinics. According to stakeholders, UNFPA also reacted outstandingly during the migrant crisis by procurement of dignity kits, conducting a needs assessment for SRH/GBV, appointing a GBV specialist in the area affected the most by migrant crisis, establishing services for GBV victims, and helping local structures respond to crisis by ensuring training and developing GBV SOP. [COAR, 2014, p. 31-2, and stakeholders confirmed]

<p>PD Establishing two new centres for healthy ageing in flood-affected municipalities, thus establishing good practice of services available and promoting the rights of older persons. [COAR 2014]</p>			
Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<p><u>EQ2.B Assumption 2: The current UNFPA CP reflects and is effectively aligned with these key policy/strategy areas: UNFPA Strategic Plan and strategies, goals of ICPD PoA, and the SDGs.</u></p> <p>[NB: The SDGs were not adopted at the time of CPD drafting and approval. There is room in the country/territory level strategic documents to respond to changes over time, and to react to emergencies. Two issues: a) respond to changes in context of changes in national environment, SDGs, and b) respond to emergencies. The country/territory has documents that should be ready for use for both types of changes. Did the country/territory programme actually respond as anticipated within the timelines etc.]</p>	<p>1. Degree of concurrence of UNFPA CP with UNFPA Strategic Plan, (2014-17 and 2018-21) policies and strategies, goals of ICPD PoA, and the SDGs.</p>	<p>1. UNFPA, ICPD and MDG, SDG policy and monitoring documents 2. Key Senior Policy informants within the four country/territory Ministries, UNCT and development partners.</p>	<p>1. Document review 2. Key stakeholder interviews. NB: The above for each of the four program areas).</p>
<p>EQ2.B Assumption 2:</p> <p>SRHR SDGs were not adopted at the time of CPD drafting and approval. UNFPA Strategic Plan 2018-2021 lists SDG indicators relevant for UNFPA’s strategic goal. COARs do not reflect activities in relation to SDGs in the area of SRHR. However, some UNFPA interventions in SRHR are pertinent to SDGs. For example, UNFPA activities related to SRH policy making and Family Planning Repositioning are directly related to the SDG 3 on Good Health and Well-being and the SDG target 3.7. “By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes”, while the activities related to maternal mortality surveillance are related to SDG target 3.1. “By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births”.</p> <p>YOUTH SDGs were not adopted at the time of CPD drafting and approval. UNFPA Strategic Plan 2018-2021 lists SDG indicators relevant for UNFPA’s strategic goal. COARs do not reflect activities in relation to SDGs in the area of Youth and Adolescents. However, some UNFPA interventions in this programme area are pertinent to SDGs. For example, UNFPA activities related to Youth and Adolescents are directly related to the SDG 3 on Good Health and Well-being and the SDG targets 3.1. “By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births”, 3.3. “ By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases”, “By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes” (specific reference to indicators 3.7.1 proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods and 3.7.2 Adolescent</p>			

birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group)).

GE SDGs were not adopted at the time of CPD drafting and approval. UNFPA Strategic Plan 2018-2021 lists SDG indicators relevant for UNFPA’s strategic goal. COARs do not reflect activities in relation to SDGs in the area of GE. However, some UNFPA interventions in GE are pertinent to SDGs. For example, UNFPA activities related to GBV/CRSV are directly related to the SDG 5 on Gender Equality and the SDG target 5.2. “Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation”, and 5.6. “Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences”

PD SDGs were not adopted at the time of CPD drafting and approval. However, some UNFPA interventions in PD are pertinent to SDGs. 17.18 By 2020, enhance capacity-building support to developing countries, including for least developed countries and small island developing States, to increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts

17.18.1 Proportion of sustainable development indicators produced at the national level with full disaggregation when relevant to the target, in accordance with the Fundamental Principles of Official Statistics

17.18.2 Number of countries that have national statistical legislation that complies with the Fundamental Principles of Official Statistics

17.18.3 Number of countries with a national statistical plan that is fully funded and under implementation, by source of funding

17.19 By 2030, build on existing initiatives to develop measurements of progress on sustainable development that complement gross domestic product, and support statistical capacity-building in developing countries

17.19.1 Dollar value of all resources made available to strengthen statistical capacity in developing countries

17.19.2 Proportion of countries that (a) have conducted at least one population and housing census in the last 10 years; and (b) have achieved 100 per cent birth registration and 80 per cent death registration

Older persons

10.2 By 2030, empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status

10.2.1 Proportion of people living below 50 per cent of median income, by age, sex and persons with disabilities

Migration

10.7 Facilitate orderly, safe, regular and responsible migration and mobility of people, including through the implementation of planned and well-managed migration policies

10.7.1 Recruitment cost borne by employee as a proportion of yearly income earned in country of destination

10.7.2 Number of countries that have implemented well-managed migration policies

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
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<p><u>EQ2.B Assumption 3: It is assumed that the UNFPA CP has explicitly attempted to attain consistency with the four separate areas: UNFPA policies, ICPD PoA, MDGs and the SDGs. NB: The SDGs were not adopted at the time of CPD drafting and approval.</u></p>	<p>1. Evidence of explicit commitments on the part of UNFPA CP team to achieve consistency with the four areas.</p>	<p>1. UNFPA, ICPD, MDG, SDG and country/territory PoC policy and monitoring documents. 2. Key informants.</p>	<p>1. Document review, 2. Key stakeholder interviews.</p>
<p>EQ2.B Assumption 3:</p> <p>SRHR The CPDs make clear reference to UNFPA Strategic Plans. The CPD 2010-2014, when defining outputs for SRHR component, refers to the outcomes 1, 4 and 5 of the UNFPA Strategic Plan 2008-2011, while the CPD 2015-2019(2020) states alignment with the UNFPA Strategic Plan 2014-2017. There is no evidence of changes of CPD 2010-2014 in line with extension of the 2008-2011 Strategic Plan through 2013, or CPD 2015-2019(2020) in line with the new 2018-2021 Strategic Plan. There is no reference to ICPD PoA or MDGs in CPDs, while SDGs were not adopted the time CPD drafting and approval. In practice, however, the interventions planned in the area of SRHR are relevant in relation to these documents.</p> <p>YOUTH According to the UNFPA Strategic plan 2014-2017, “Women, adolescents and youth are the key beneficiaries of UNFPA work”. Three desired outputs of UNFPA Strategic Plan 2018-2021 target youth and adolescents, including girls. The CPD 2015-2019(2020) reflects these priorities. UNFPA CPDs do not quote the ICPD goals but they are reflected in the CP. In the area of Youth and Adolescents, the interventions are clearly in line with the ICPD objectives related to children and youth, including youth participation in policy making, youth access to SRH services and education, and elimination of child marriages. SDGs were not adopted at the time of CPD drafting and approval. However, some UNFPA interventions in this programme area are pertinent to SDGs.</p> <p>GE The CPDs make clear reference to UNFPA Strategic Plans. The CPD 2010-2014, when defining outputs for SRHR component, refers to the outcomes 1 and 3 of the UNFPA Strategic Plan 2008-2011, while the CPD 2015-2019(2020) states alignment with the UNFPA Strategic Plan 2014-2017. There is no evidence of changes of CPD 2010-2014 in line with extension of the 2008-2011 Strategic Plan through 2013, or CPD 2015-2019(2020) in line with the new 2018-2021 Strategic Plan. There is no reference to ICPD PoA or MDGs in CPDs, while SDGs were not adopted at the time of CPD drafting and approval. In practice, however, the interventions planned in the area of GE are mostly relevant in relation to these documents, while as mentioned earlier, some activities do not stem directly from these documents, e.g. stigma alleviation and work with perpetrators.</p> <p>PD The CPDs are generally in line with UNFPA Strategic Plans. One exception is the work on migration data and ageing, however these could be understood as population policies, just like the youth policy and SRH policy. There is no reference to ICPD PoA or MDGs in CPDs, while SDGs were not adopted at the time of CPD drafting and approval. In practice, however, the interventions planned in the area of PD are relevant in relation to these documents.</p>			
<p>EFFECTIVENESS (APPLIES TO ALL FOUR FOCUS AREAS)</p>			
<p>EQ3. To what extent have the intended programme outputs been achieved? To what extent did the outputs contribute to the achievement of these planned outcomes: (i). increased utilization of integrated SRH Services by those furthest behind, (ii). increased the access of young people to quality SRH services and sexuality education, (iii). mainstreaming of provisions to advance gender equality, and (iv). developing of evidence-based national population policies; and what was the degree of achievement of the outcomes?</p>			

<i>EQ3.A To what extent have the intended programme <u>outputs</u> been achieved?</i>			
Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ3.A Assumption 1: Assumes intended and unintended program outputs have been achieved to some extent.</u>	<ol style="list-style-type: none"> 1. Quantitative: Level of achievement against indicators/targets (as outlined in CP monitoring framework) over time within each of the four program areas: SRH, Youth, Gender and PD. 2. Qualitative: Stakeholder perceptions of achievement (quantity and quality) of outputs within each of the four program areas: SRH, Youth, Gender and PD 3. Good practices (strategy, achievement etc.) 	<ol style="list-style-type: none"> 1. AWP, COARs, Project Reports, CP, Revised CP Framework. 2. Stakeholders. 3. Most recent surveys and other available data within each of the four program areas: SRH, Youth, Gender and PD. 	<ol style="list-style-type: none"> 1.1 Document review. 1.2 Stakeholder interviews
EQ3.A Assumption1: Findings including analysis for all pertinent program areas: 1. Sexual and Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD.			
<p>SRHR In order to assess the extent to which the intended programme outputs have been achieved over two programming cycles, a selection of comparable outputs has been made. Some promotional activities and participation in conferences, seminars were not evaluated. These outputs are “Health ministries coordinate and develop intersectoral family planning and reproductive health commodity security policies and strategies to improve women’s health” from the CPD 2010-2014 and “Increased national capacity at state and entities level to deliver integrated sexual and reproductive health services, with focus on Roma and vulnerable populations” from the CPD 2015-2019(2020). It is important to note that the output from CPD 2010-2014 is one among four under one outcome related to Sexual and Reproductive Health and Rights, while the comparable output from CPD 2015-2019(2020) is the only output under the outcome related to Sexual and Reproductive Health. The targets set for these outputs are the following: Family [planning] policy action plan established at entity levels, Number of guidelines, protocols and standards for healthcare workers developed for delivery of quality SRH services (including adolescents and youth), Percentage of service delivery points at primary health-care level providing at least three integrated reproductive health services, Mechanism for maternal death surveillance and response system established at state and entities levels, Elements of Minimum Initial Service Package for reproductive health in crisis situations integrated into state emergency preparedness plans.</p> <p>When is comes to Family Planning, UNFPA reported in its 2013 Annual Report that “UNFPA BiH worked on a needs assessment to develop strategic recommendations regarding activities in the area of FP/RH, including youth, gender-equality and provision of high-quality standardized FP services. Two meetings with key national stakeholders were held to acquaint and debrief, respectively, the stakeholders on the objectives and to get approval and coherence in future programming. Further steps were discussed and agreed on how to increase access to FP services, future capacity building.” Along with this activity, UNFPA worked on introduction of the concept of Total Market Approach (TMA) and brought together different national stakeholders to acquaint them with what the public sector, commercial suppliers, and nongovernmental organizations can do to ensure a reliable supply of reproductive health commodities, in particular for family planning and HIV prevention. This activity</p>			

resulted in a TMA Action Plan. According to the 2014 Annual Report, this year featured preparatory and advocacy activities to address existing gaps in the family planning system in the country and formulate future steps for family planning as per the signed CPD 2015-2019(2020), having in mind recommendations from the Report on Market Segmentation of Contraceptives assessment. These recommendations included, among other things, “specialist and continuing education of gynaecologists, family physicians, pharmacists and nurses in family planning” [2014 country report]. However, despite a noted interest among policy makers and health workers in providing family planning services and modern contraception as a preferred option to continued reliance on traditional methods and abortion, the target defined under the relevant output was not met, and the Family [planning] policy action plans at entity levels do not feature as results in UNFPA’s annual reports for the final two years of CPD 2010-2014. However, the beginning of implementation of the new CPD 2015-2019(2020) was marked by concrete interventions to implement recommendations from the Market Segmentation Report. According to the 2015 Report, capacities of family physicians and gynaecologists from primary health care were developed/strengthened to deliver training on family planning through the Family Planning training package (developed with the support of ECCARO’s IP EEIRH) and Training of Trainers. These doctors delivered trainings in 2016, 2017 and 2018 to participants from 28 communities [according to PPH list of participants], ending up training the total of 318 family physicians by the end of 2018 [this is from PPH report, while UNFPA report for 2017 says 259 trainees]. UNFPA reported that these physicians were now able to “deliver human rights-based and patient centered family planning counselling and services.” Although planned in 2015, the working group for developing a module for family planning for community nurses was not established. However, in 2016, UNFPA BiH established cooperation with SDC funded project ProSES and supported the development of family planning modules for community nurses, which were supposed to be integrated in the degree program of community nurses in BiH, with ProSES planning to hold the trainings in the coming years across BiH. In the subsequent reports of UNFPA BiH, the results of this activity were not mentioned. Activities related to demand generation for family planning were reported as completed, with a caveat that the dissemination of messages could not be measured and that social marketing could not be done, which remained the case through 2017. In 2017, the existing Family Planning Curriculum was enriched with two new modules (one on STIs and the other one on youth friendly approaches) hence adding value to existing promotion of family planning in the country, as well as delivering human rights-based and patient-centred family planning counselling and services. However, according to stakeholder interviews, training on these topics has not yet been delivered. The relevant target for this output (which goes wider than family planning repositioning only) is 25% of service delivery points at primary health-care level providing at least three integrated reproductive health services. It could be argued that by delivery of training for family physicians and accompanying promotional activities at 18 localities, the target was partly met. The stakeholders interviewed praised the trainings delivered to family physicians by teams of doctors (family physicians and gynaecologists forming teams and dividing teaching topics amongst themselves). It was noted that the training consisted of four modules, adapted to local context from best international practices, and delivered by trainers who were trained to deliver substantive training to adult professionals. The substance consisted of topics related to legislation, ethics, logistics, contraception and counselling.

Another output under this programme area is development of clinical guidelines for maternal health. The preparatory work and planning for development of these guidelines started in 2014 and rolled out in subsequent years. In 2015, the Ministries appointed a working group to work on drafting on postpartum haemorrhage (PPH) clinical guidelines by adapting from international best practices. In 2016, as a result of joint efforts between EECARO, their IP Eastern European Institute for Reproductive Health and CO a team of experts developed first ever evidence based PPH clinical guidelines, adapted using an internationally recognized methodology for the development of clinical guidelines. The guidelines were endorsed by both health ministries, presented to around 300 professionals, and widely publicised in the media. In the same year, work on preeclampsia guidelines started, but did not finish in 2017. CO supported development of Guidelines for Development of Clinical Guidelines as a step-by-step guide on the methodology how future guidelines should be developed, as this resource was found to be missing in the country. Stakeholders interviewed commended this process and final results as a very big contribution to informing practice of healthcare workers, They said that such clinical guidelines were very relevant for maternal health and very much needed by clinics. This was confirmed as a quality requirement for medical institutions and the accreditation agencies, which endorsed the guidelines, played an important role. PPH posters containing guides/algorithms have been displayed in 14 medical institutions in RS in critical/visible places in delivery rooms. According to stakeholders, the eclampsia guide should be disseminated wider because other doctors are also involved in monitoring pregnancies. In terms of target for this output, four

guidelines, protocols and standards for healthcare workers for delivery of quality SRH services are expected to be delivered as part of 2015-2019(2020) CP. So far, three guides were drafted. According to stakeholders, the fourth guide, on pregnancy monitoring should be developed too.

In 2014, UNFPA started activities on the initiative “Expanding Beyond The Numbers-Maternal Mortality and Morbidity Case Reviews” by supporting participation of representatives from BiH in a regional workshop with a view of introducing the BTN tools and methodology to countries/territory in the Eastern European Region. This was followed by advocacy of Beyond the Numbers methodology as a precursor to developing the country/territory action plan. Initial methodology training was provided by RO, through BtN workshop held in Sarajevo, while the development of methodology started in 2016. In 2017, a group of trainers of trainers were trained to use the WHO “Beyond the Numbers” methodology and entities’ working groups have been established to lead this process [information from annual reports]. In 2018, according to stakeholder interviews, the work on BtN continued with attempts to develop action plans for rollout and piloting the methodology in institutions. Some stakeholders praise this initiative of UNFPA, says that although BiH is a country with low maternal mortality, the surveillance should be extended to near miss cases during pregnancy and 42 days after delivery. Individual stakeholders stated that the BtN system was not adapted to BiH and that health institution managers were not necessarily open for this kind of surveillance. As a whole, it could be argued that the output indicator was not met as a mechanism for maternal death surveillance and response system has not been established at the state and entity levels.

Although it could be rather placed under one of the outcomes from CPD 2010-2014, another UNFPA intervention featured highly in COARs and stakeholder interviews, and this is work on development of SRH policies. This work is first reported in the 2017 Annual Report although the work on SRH strategies had been planned a couple of years earlier. It could be gathered from stakeholder interviews that the RS SRH strategy was successfully drafted in 2018 and would be submitted for adoption in 2019. The stakeholders interviewed generally expressed satisfaction with the process of drafting of SRH strategy, UNFPA’s support and the final contents of the Strategy and the accompanying Action Plan, which is said to be adapted to marginalized groups too. The FBiH authorities decided not to pass any general strategies until 2021. For this reason, the Health Ministry decided to do a transitional and refreshed SRH strategy.

YOUTH In order to assess the extent to which the intended programme outputs have been achieved over two country programming cycles, a selection of comparable outputs has been made. These outputs are “Service providers in the health, education, social protection and judiciary sectors have improved knowledge and skills to increase the access of youth and women to high-quality social services, and to empower them to make decisions on nutrition and reproductive health” from the CPD 2010-2014 and “Increased national capacity to conduct evidence-based advocacy for incorporating the human rights and needs of adolescents and youth in national laws, policies and programmes, including in humanitarian settings” from the CPD 2015-2019(2020). It is important to note that the output from CPD 2010-2014 is one among four under one outcome related to Reproductive Health and Rights, while the comparable output from CPD 2015-2019(2020) is the only output under the outcome related to Youth and Adolescents. The targets set for these outputs are the following: Number of peer education clubs in schools, Number of policies or programmes at state and entities level that address or include marginalized adolescents and youth needs, Percentage of secondary schools that introduce comprehensive sexuality education aligned with international standards, and Number of country-wide civil society initiatives addressing adolescent girls at risk of child marriage.

Support to peer education on SRH in an activity under the CPD 2010-2014. In this CPD, it was reported that previously UNFPA had supported peer education and counselling for youth on SRH and it was concluded that this practice should be replicated and the number of peer education clubs in schools increased from the baseline of 24 to 34. There does not seem to be evidence that this target was achieved and that earlier work had been replicated. In 2014 COAR, UNFPA reported that the overall situation was challenging, as the NGO-provided peer education has not been institutionalized. In the subsequent years, UNFPA reported only isolated advocacy actions on SRH by Y-PEER.

Still, this work seems to have been followed up by more systemic interventions, that is, integrating comprehensive sexual education into school curricula. This intervention started in 2013 following the example of Sarajevo Canton, which had integrated the “Healthy Lifestyles” subject into primary school curricula with help of the Association XY. Although not involved in the original creating and endorsement of the curriculum, UNFPA did support the Association XY in raising awareness of school directors and teachers to promote higher enrolment of students to this subject (which was envisaged as one of three optional subjects, the other two being religious classes and culture of religions), and also in developing instruments to evaluate implementation of this subject. UNFPA launched an initiative to review the Healthy Lifestyles Curriculum, which was introduced in Sarajevo, to check it against international standards. Only after this was the opportunity for expansion to another canton in FBiH seized. According to interviews with stakeholders and UNFPA COARs, the integration of Youth Health subject into primary school curricula in the Bosnian Podrinje Canton has been very successful in the period 2016-2018. This was a well thought out process, where the education authorities in the Bosnian Podrinje Canton did not want to replicate the model from the Sarajevo Canton by default, but decided to make choices adapted to their needs and policies and make this subject compulsory and taught by head teachers for the 6th to 9th grades. The Association XY, as UNFPA’s implementing partner, supported the process of drafting the syllabus and guide for teachers, and delivered training to head teachers. The trainees interviewed gave excellent grades for the training delivered and said that they were already implementing the Youth Health subject in the academic year 2018/2019. UNFPA is aware that integrating CSE into school curricula is a difficult process, including replicating results from Sarajevo and Bosnian Podrinje Cantons to the rest of the country, which is why it has engaged in a number of promotional and advocacy activities, including contributing to production of a promotional video by EECA RO for countries/territory of the region and furthering advocacy efforts in FBiH and RS. A demonstration of this is UNFPA-commissioned survey on Youth Views on CSE as a Part of Formal Education from December 2017, which also surveyed young people’s knowledge of SRH. The survey findings suggested that internet was the common sources of knowledge in this area, followed by peer education, and teachers. Almost all respondents said that reproductive health should be taught at school. It is, however, unclear how the findings of this survey will be used in further advocacy efforts, although the information about internet sources of knowledge was reflected in a specific CP activity related to making of a web platform www.spolnozdravlje.ba. Analysis of UNFPA’s advocacy and partnership plans suggested that UNFPA’s plans to replicate CSE integration into school curricula across the country have not been ambitious enough. The target set in the CPD 2015-2019(2020) is 13 percent of secondary schools, which means that this target has not been pursued yet as all efforts for integration of CSE was related to primary schools.

Concerning youth’s access to SRH counselling and services, AWP and COARs do not indicate substantial activities under the Youth and Adolescents component, except that CO has organised a hackathon to develop SRH-related smartphone application and web platform for youth and adolescents in order to ensure easily accessible and correct information is provided to this population group. The platform is available on www.spolnozdravlje.ba and currently maintained by the Association XY, although it is expected that the RS and FBiH health authorities will take over this link.

When it comes to support to development of policies that address youth and adolescent needs, UNFPA supported drafting of Youth Strategies for RS and FBiH, the Youth policy RS 2016-2020 and Strategy for Youth FBiH 2016-2020. RS successfully adopted the Youth policy in 2016 but due to lack of commitments for funding of the planned activities, the process of preparation and adoption of accompanying Action Plan was postponed for 2017. FBiH is yet to pass the youth policy and CO worked on advocating with the relevant ministry for document’s adoption. However, the draft strategy has become outdated, as of all Ministries in FBiH, only the Ministry of Finance did not give a positive opinion on this policy. According to COARs, both documents contain relevant information on ASRH and CSE. This was confirmed by interviewed stakeholders, who said that UNFPA insisted on several key aspects of policy drafting, most notably the focus on education, SRH and gender equality, and engagement of youth in policy drafting. Looking at the targets set under CPD 2015-2019(2020), the target of having two pertinent policies has been only partly met. UN Youth Strategic Document could be understood as another policy development intervention in which UNFPA participates. There is no evidence in COARs that this initiative has progressed. It was found in stakeholder interviews that a consultant is currently mapping UN work on youth, but the outcome of this initiative is still unknown.

A specific intervention, which is in line with international policy frameworks and UNFPA strategic plans, which carries an innovative element in UNFPA CP, is related to prevention of early marriages. This activity has stretched over three years, from 2014 to 2016, including training and script writing, according to COARs and it resulted in cooperation with UNICEF and organization of 11 theatre plays in two schools with predominantly Roma children. The stakeholders said that the plays increased awareness of early marriages in Roma population, but the effects on delaying marriages were not certain and these activities required follow up. The target of having two initiatives by CSOs has been met.

GE In order to assess the extent to which the intended programme outputs have been achieved over two country programming cycles, a selection of outputs has been made. These outputs are: 1. tracking and reporting mechanism to follow up on the implementation of reproductive rights recommendations and obligations established at state and entities level, 2. Gender-based violence prevention, protection and response integrated into national sexual and reproductive health programmes, 3. number of civil society initiatives involving men and boys in addressing gender-based violence.

The first output has not yet been implemented. Preparatory baseline studies had been conducted in 2015, as reported for 2015. The 2017 COAR indicates that an RO initiative related to SRHR/SDG indicators was awaited (scanning by RO of the whole cluster and taking into account specifics of each country/territory). According to this report, “UPR reporting mechanism was abandoned in favor of assisting the state structures in developing an SDG-centric reporting system that also captures data relevant to gender equality and violence prevention”.

The second output constitutes a good part of UNFPA’s reported interventions. Specific and thorough actions have been taken in both entities in BiH in this field. They are largely related to production of relevant resource packs for health care system’s response to GBV and CRSV. This work has been done over the years. In 2015, relevant assessments were produced and this was followed up by development of two resource packages for health sector response to GBV/CRSV, containing guidelines and training material for health professionals and their endorsement by the FBiH Ministry of Health and the RS Ministry of Health and Social Welfare. In 2016, Training of Trainers for health sector’s response to GBV was held and the rollout of training started. By the end of 2018, the total of 277 service providers in the health and social sectors received training on response to GBV/CRSV (47 men and 230 women, calculation from PPH lists of participants). The training covered primary health care professionals, but also professionals from mental health centres and social welfare centres. Of the number, seven professionals received training on psychosocial support to perpetrators, while the rest of training was directed at victims. Thanks to technical assistance internal health system’s protocols for GBV were developed and endorsed by line ministries in FBiH and RS. This resulted in developed protocols for Gorazde primary health care clinic and Banja Luka primary health care clinic. These protocols have also been validated and formally put into force. By the end of 2018, two comprehensive resource packages have been produced for response of the health sectors to GBV/CRSV in FBiH and RS. In FBiH, the resource package consists of 11 knowledge and operational products including a resource pack for strengthening health sector’s response to GBV, training modules and materials for health sector’s response to GBV, psychosocial treatment of GBV and CRSV victims, psychosocial treatment of GBV perpetrators, the role of youth in protection from GBV in general and in crisis, treatment of GBV victims in crisis, and two protocols for treatment of GBV victims (localized in Gorazde and Brcko). In RS, the package consists of eight knowledge and operational products, including a resource pack for strengthening health sector’s response to GBV, a resource pack for strengthening psychosocial treatment in cases of GBV, training modules for health sectors’ response and psychosocial response to GBV, minimal standards for prevention and response to GBV in crisis, and protocol for treatment of GBV victims localized in Banja Luka. Stakeholders have confirmed the value of these documents, stressing their alignment with global UNFPA documents (which have been adapted to the local context thanks to help of entity ministries and local professionals) and with the Istanbul Convention. According to some, in the area of health sector’s response to GBV, these interventions have contributed to the biggest breakthrough in this area in the past 10 years. When it comes to implementation of the standards set and operating procedures, an example from Banja Luka is illustrative, where the GBV SOP has been

fully and formally integrated into health care centre's work. The procedure for treatment of GBV victims was verified by the Quality Department of this institution, it was registered under a specific code and has the same status as all other mandatory procedures in the health centre, while all staff have been familiarized with it. Similarly, the protocol was formalized in the Gorazde Health Care Centre, and according to stakeholders, replication to other communities is likely to ensue.

Concerning the output related to number of civil society initiatives involving men and boys in addressing gender-based violence, the target for this output from CPD 2015-2019(2020) is three in relation to the baseline of 1. From the COARs, there is no evidence that this target was achieved. Instead, focus was moved to other gender transformative initiatives, including a Study of Masculinities and Gender-Based Violence against Women in BiH and youth theatre plays for alleviating stigma against CRSV victims. Other gender transformative initiatives included support for BiH's Women's Football Team, which is another demonstration of innovative approaches to transformation of traditional gender roles.

Other outputs of UNFPA in the area of GE, or rather responses to GBV/CRSV have been considerably directed at alleviating stigma against victims of CRSV. This work began in 2015 with baseline research on stigmatization of CRSV victims. Stigma alleviation has been approached by UNFPA CO from at least three different angles - youth theatre plays, work with the Inter-religious Council, and work in selected municipalities on implementation of stigma alleviation programme. Youth theatre plays were organized at 12 locations by the end of 2018 and initiatives in local communities supported. Key stakeholders from the selected three locations (Gorazde, Bijeljina, Sanski Most) have formed groups that have been presented with the key elements of the Stigma Alleviation Plan and have developed local action plans for alleviation of stigma in their respective communities. Implementation of said plans is planned for the following period. Apart from this, a promotional video was produced <https://ba.unfpa.org/en/video/fighting-stigma-against-survivors-conflict-related-sexual-violence>. Breakthrough results have been achieved in work with the IRC, as a Declaration on Denouncing stigma against CRSV survivors was prepared, publicly signed and announced in 2017. Cooperation with IRC continued into 2018 and a joint Manual of the Inter-religious Council in Bosnia and Herzegovina for members of the clergy working with survivors of conflict related sexual violence was produced and promoted. This was the first intervention of this kind in the world, as reported by stakeholders. The manual was created by psychotherapists and theologians together, and it looks at treatment of CRSV victims from both of these perspectives. It was reported that as a result of work with IRC and local communities, clergy of all four major faiths started engaging in local dialogue to prevent stigmatization of CRSV victims and ensure referral to relevant services. According to some stakeholders, the work on stigma alleviation has also encouraged initiatives for reparation of damage. On top of this, as a result of the UNFPA CP, the total of 15 media professionals received training on contextualized reporting on CRSV and guidelines on reporting on CRSV. There is no evidence on follow up on these activities and measurement of their effects.

PD Four key outputs were selected for evaluation of effectiveness of UNFPA CP under PD deployment - establishment of migration database, development of Strategies for Improving the Status of Older Persons, establishment of Healthy Ageing Centres, and advocacy for evidence-based population policies.

The output related to migration under CPD 2010-2014 was formulated as "Government and statistical agencies have increased knowledge and skills to establish a migration surveillance system and to integrate it into the development and implementation of strategies and policies". It was reported in 2013 that an overall migration statistics methodology was developed in cooperation with the BiH Agency for Statistics, thus increasing its capacities through technical assistance. At the same time, work was done with the BiH Ministry of Security on establishment of a migration software, which was reported as completed in 2014. The hardware and software were procured. This intervention was delivered in line with Eurostat requirements for monitoring of migrations, as per EU requirements from BiH on its path toward accession to the EU. According to stakeholders, however, these resources have not been put to efficient use at the time, as the technical and methodological solutions were not integrated into the BiH Ministry of Security's migration information system and the BiH Agency for Statistics could not access the migration data. The stakeholders have confirmed continued relevance of this activity and the need for monitoring of external migrations, integration of two statistical systems, and efficient reporting to Eurostat. The

promising news is that the BiH Ministry of Security is working on reengineering its Migration Information System and is planning to integrate the results previously achieved under YERP (by UNFPA). The aim is to ensure sufficient business intelligence that will enable exchange of statistical information with the BiH Agency for Statistics. Looking at the indicator of success for this output under CPD 2010-2014, it is unknown which number of government and civil society professionals were trained in collecting, processing and interpreting migration data disaggregated by sex and age. However, the migration database was established, although not put in use effectively so far.

When it comes to the CPD 2010-2014 PD Output “Officials of the Directorate for Economic Planning have the knowledge and skills to implement the Madrid International Plan of Action on Ageing through the European regional implementation strategy and through strategies for older persons”, and the output indicator “Parliamentary Assembly adopts the Madrid International Plan of Action on Ageing,” the MIPAA was adopted by the BiH authorities. However, looking at the output from the CPD 2015-2019(2020) “Strengthened institutional capacity for the formulation and implementation of rights-based policies and implementation that integrate evidence on emerging population issues (low fertility, ageing and migration) and their links to sustainable development”, the work on Strategies for Improving the Status of Older Persons is directly related to this output. One of the output indicators for this output is “Number of policies developed at state and entities level using secondary analysis of census data” and the target set was three in relation to the baseline of zero. In fact, two strategies were drafted in cooperation with entity authorities and civil society. The RS Strategy is on the agenda of the RS People’s Assembly awaiting debate, while the FBiH Strategy adoption has been stalled by general election and slow formation of government in FBiH. Both strategies are elaborate documents, drafted by local professionals, containing needs assessment based on the available statistical data, identification of strategic priorities, operationalization and monitoring and evaluation plans. Both strategies have been created through a wide consultative process with interested stakeholders and UNFPA has greatly assisted this process. Given that the output from CPD 2015-2019(2020) has been broadly defined, links with other components of UNFPA CP and deliverables should be noted. Namely, the work on youth and SRH strategies evaluated in the sections above directly relate to the achievement of this output, although not placed under the same PD component of UNFPA CP. This separation may seem logical, given different portfolios within the CO, but the linkages between these deliverables are evident. There is evidence that PD component staff has rendered assistance in the drafting of some of the mentioned strategies. Stakeholders have confirmed the value of UNFPA’s input in drafting of Strategies on Ageing and expressed satisfaction, as UNFPA has been singled out as the only international agency committing to work on issues related to the status of older persons.

When it comes to establishment of and support for Healthy Ageing Centres, it should be noted that this output has not been foreseen by the CPDs. However, good practice in Sarajevo was observed, and in line with expressed needs, the rights-based approach, and the ICPD agenda for older persons, UNFPA decided to support these centres. During the floods, two Health Ageing Centres were established in Modrica and Samac-Domaljevac, with the help of the first Healthy Ageing Centre in Sarajevo. This was evidence of replication of good practice and knowledge exchange. The Research about impact of centers for healthy ageing on the health of beneficiaries has been used for advocacy of opening of such centres in local communities, according to 2015 and 2016 reports. The process of opening of Healthy Ageing Centres has continued, expanding to Tuzla, Banja Luka and Zenica. Today in BiH, 11 of Healthy Ageing Centres are operational, although not all to a satisfactory standard. The users of Healthy Ageing Centre in Sarajevo were interviewed (this centre has become the educational centre and knowledge hub for all healthy ageing centres). Their testimonies indicated great satisfaction with the work of this centre and support for the dignity of third age. While enlisting all activities that they had at their disposal in the centre, and making proposals for additional services (mostly medical and artistic), the users highlighted that the centre added value to their lives, health and general well being. They support further replication of practice and said that they participated in replication by visiting newly established centres and sharing their experiences.

One output indicator for the CPD 2015-2019(2020) output “Strengthened institutional capacity for the formulation and implementation of rights-based policies and implementation that integrate evidence on emerging population issues (low fertility, ageing and migration) and their links to sustainable development” is “Population

situation analysis conducted to identify priorities and formulate policies and programmes”. According to reports and stakeholders, there has been continuous advocacy of development of evidence-based population policy development. However, comprehensive population policies have not been developed at any level of government in BiH. Still, there have been efforts on the part of UNFPA to develop youth, SRH, and strategies on ageing, constituting segments of a comprehensive population policy. UNFPA has promoted the ICPD agenda (COAR 2013) as well SDGs among its stakeholders. According to COAR 2016, “CO has continuously advocated with the UNCT, institutional and development partners for development of SDG monitoring and reporting framework, within wider process of SDG localisation in the country. This work was further underpinned by RO support, when partners from the country had an opportunity to attend regional high level discussions in Geneva on linkages between ICPD and SDG indicators. As a result of this meeting, representatives of the BiH Agency for Statistics and the BiH Directorate for Economic Planning understood the need for prioritising SDGs in the context of country’s development as well as development of a system for regular reporting on SDGs.” This was confirmed by stakeholders interviewed, who stressed the need for support in localization of SDGs and support for statistical institutions in. However, it was also noted by stakeholders that the institutional capacities were weak to absorb assistance and undertake the challenging job related to measuring of achievement of SDGs. Generally in the area of development of evidence-based population policies, stakeholders have reported rather scattered work of UNFPA since the preparation for census. This mostly has to do with the failure of UNFPA to help data production. Namely, data production and collection is costly for both UNFPA and local institutions, which means that up to date data relevant for population policies can hardly be gathered. Namely, MICS has not been carried out for several years, while DHS has never been conducted either. UNFPA has been advocating for better data collection and processing in BiH, but has not had the resources to contribute with direct data production, in line with the UNFPA strategic plans, since the Prevalence Survey. It is promising, however, that UNFPA will support the Population Situation Analysis, and the Population Projections, in cooperation with statistical institutions in BiH, in 2019, and stakeholders have welcomed this as very valuable and needed deliverables. By producing the Population Situation Analysis, the relevant output indicator from CPD 2015-2019(2020) will have been observed.

EQ3.B To what extent have the intended programme outcomes been achieved?

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ3.B Assumption 1: Assumes all intended and unintended outcomes have been achieved to some extent.</u>	<ol style="list-style-type: none"> 1. Trend analysis (outcome indicators) to identify achievement of selected outcome indicators 2. Stakeholders’ perspectives of changes (static/ positive/negative) 3. Stakeholders’ perspectives on the most significant changes that have happened. 	<ol style="list-style-type: none"> 1. Secondary data (survey, census, reports etc.) 2. Stakeholders 	<ol style="list-style-type: none"> 1.1 Document review. 1.2 Stakeholder interviews

EQ3.B Assumption 1: Findings including analysis for all pertinent program areas: 1. Sexual and Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD.

SRHR Increased utilization of integrated SRH Services by those furthest behind. It is understood that integrated SRH services include Family planning/birth spacing services, Antenatal care, skilled attendance at delivery, and postnatal care, Management of obstetric and neonatal complications and emergencies, Prevention of abortion and management of complications resulting from unsafe abortion, Prevention and treatment of reproductive tract infections and sexually transmitted infections including

HIV/AIDS, Early diagnosis and treatment for breast and cervical cancer, Promotion, education and support for exclusive breast feeding, Prevention and appropriate treatment of sub-fertility and infertility, Active discouragement of harmful practices such as female genital cutting, Adolescent sexual and reproductive health, Prevention and management of gender-based violence. Those furthest behind are persons with disability, people at risk of HIV infection, Roma, as well as socially excluded groups of women, men and young people.

In terms of Family Planning interventions as part of UNFPA CP, more specifically the delivery of training on Family Planning for family physicians, according to UNFPA 2017 Annual Report, despite initial reluctance, family physicians pledged after training that they would offer family planning services in their daily work, especially to young people. According to some stakeholders who were interviewed, the actual result of this activity is that family physicians will no longer reject giving advice to patients seeking family planning advice, or give them repulsing statements about contraception. Other stakeholders, however, said that family planning counselling by family physicians still depended on the will, enthusiasm and affinities of individual family physicians, particularly having in mind their generally high workload and time that they can spend with patients. Some argued that the topic of Family Planning needed to be deeply embedded in medical schools' curricula as well as work discipline. It was noted by some stakeholders that although they received good feedback training and family planning repositions, there was no specific evaluation on how much this concept has been applied in practice. Also, stakeholders views on how adapted the Family Planning repositioning concept was to marginalized groups varied, as some said that the concept was developed as one-size-fits-all, while others argued that specific attention was paid to marginalized groups such as persons with disabilities, Roma, etc. For this reason, no clear conclusions could be drawn on the delivery of this part of integrated SRH services to marginalized groups. The lack of affordable contraception has been stated as an impediment to successful rollout. This indicates that contraception is not a priority for relevant authorities, particularly as BiH is a low fertility country.

Another set of services as part of the integrated SRH package is related to Antenatal care, skilled attendance at delivery, and postnatal care and Management of obstetric and neonatal complications and emergencies. The clinical guidelines for PPH and eclampsia can contribute to achievement of the overall outcome for this programme area. The fact that guidelines have been developed by local professionals, with support of international experts for adaptation to best international practices, as well as the fact that guidelines have been disseminated widely could be interpreted as contributing to increased general availability of integrated SRH services, although without information about access of specific marginalized groups to these services. Furthermore, it is hard to link the BtN interventions with this outcome at the moment, as the implementation of this methodology is still in nascent phase.

It is assumed that existence of comprehensive SRH policies will contribute to increased utilization of SRH service, particularly if these policies also target marginalized groups. Given that the RS SRH Strategy, for example, plans for cervical cancer screening, this could contribute to one set of services in the integrated SRH package, which is Early diagnosis and treatment for breast and cervical cancer. However, as it was noted by several stakeholders, a system for screening of breast, cervical, or prostate cancer, has not been established in BiH. In the 2013 Final Evaluation of CP, cervical and breast cancer screening was singled out as one of promising interventions. However, apart from a needs assessment which was conducted in 2014 and colposcopy training for gynaecologists in 2016, there is no evidence of follow up on these activities in Annual Reports. Stakeholders interviewed expressed the need for exploring options for introduction of systemic screening.

YOUTH Increased access of young people to quality SRH services and sexuality education. Two outcome indicators from two CDPs are relevant for this outcome, one related to number of municipalities with established multi-disciplinary referral mechanisms targeting socially excluded groups (CPD 2010-2014) and another related to policies in place addressing SRH needs of youth and adolescents, including marginalized youth (CPD 2015-2019(2020)). The COARs do not indicate which is the number of municipalities with established multi-disciplinary referral mechanisms, or rather peer education clubs in schools. For this reason, it is unknown to what extent youth's access to quality SRH services and sexuality education has increased or decreased. When it comes to the policies in place addressing SRH needs of youth and adolescents,

the target was 3, while there is evidence that only one policy has actually been endorsed, which is the RS Youth Policy. However, it could be argued that although the FBIH Youth Strategy has not been adopted, that the methodology for its drafting has been replicated in individual cantons, as a spillover and unintended effect of the FBIH Youth Strategy drafting. According to stakeholders, youth policies have been adopted in two cantons, the USK and ZDK, while the passage of strategy in the Sarajevo Canton was disrupted by the election cycle in 2018.

When it comes to access to sexuality education, youth's access has certainly increased as the subject Youth Health has been formally integrated as obligatory educational content for the grades 6th to 9th in primary schools of the Bosnian Podrinje Canton. Moreover, the intervention relating to creation of a web platform on sexual health is promising, but its effects are yet to be seen. The theatre plays on early marriage are expected to have increased at least the awareness on this topic, although it is unknown to what extent early marriages have been delayed.

Concerning youth's actual access to SRH services, UNFPA has not focused its interventions on health system's response to the needs of this particular category of population as part of this component although it is reported in the COARs 2016 and 2017 that "Youth friendly services module developed" and "In addition, existing Family Planning Curriculum was enriched with two new modules (one on STIs and the other one on youth friendly approaches), hence adding value to existing promotion of family planning in the country, as well as delivering human rights-based and patient-centred family planning counselling and services." A number of stakeholders have pointed out that integrating SRH services for youth into regular family medicine services is not an effective approach because youth choose to seek advice and services in places different than their parents and families. They have argued for support to establishment of specialized youth SRH services. Also, stakeholders argued that effective linkages should be established between the education and health systems in terms of provision of SRH services to youth.

GE Mainstreaming of provisions to advance gender equality UNFPA CP over the two programme cycles has generally focused on one aspect of advancing gender equality, which is prevention of and response to GBV, together with individual gender transformative initiatives. When it comes to integration of gender-based violence prevention, protection and response into national sexual and reproductive health programmes, the evidence of related outputs contributing to achievement of the overall outcome for gender equality can be found in the results achieved relating to development of resource packages (containing knowledge and operational products outlined above under outputs) for health sector's response to GBV/CRSV. More specifically, with the endorsement of these packages by line ministries, delivery of training of trainers and the rollout of training, as well as implementation of protocols for treatment of GBV and CRSV victims, generally and in crisis, it could be concluded that gender equality provisions have been mainstreamed into the health system to a large extent. This is further evidenced through stakeholders' views that this work has contributed to the biggest breakthrough in this specific field of intervention over the past several years. It should be noted that the health sector's response to GBV has already been mainstreamed as an obligation stemming from policies relating to GBV in BiH, most notably through the Laws on Protection from Domestic Violence in RS and FBiH, relevant bylaws stemming from this legislation (including rulebooks on treatment of perpetrators), but also Strategies for prevention and combatting domestic violence in FBiH and RS and the Framework Strategy for Implementation of Istanbul Convention. UNFPA's work has contributed to the mainstreaming of these provisions by providing practical instruments for implementation in practice.

When it comes to mainstreaming of gender equality provisions through other UNFPA initiatives in the field of GBV and GE in general, evidence of mainstreaming of stigma alleviation can be found in IRC's Declaration on Denouncing stigma against CRSV survivors. However, other activities related to stigma alleviation have not resulted in mainstreaming of provisions to advance gender equality, but were rather localized initiatives without formalization of rules and their integration into institutional and legal systems.

If the CPD 2015-2019(2020) outcome for GE is considered “Advanced gender equality, women’s and girls’ empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth” and the accompanying outcome indicator “Proportion of the Universal Periodic Review accepted recommendations on reproductive rights from the previous reporting cycle implemented or action taken”, it is concluded that this outcome cannot be measured by this specific indicator as the UNFPA CP abandoned the activity of establishing of a Functional tracking and reporting system to follow up on the implementation of reproductive rights recommendations an obligations in the entities pending more comprehensive work in relation to SDGs. However, it could be argued, based on the review of outputs delivered that mechanisms for better response of the health sector to GBV/CRSV have been established and integrated in the health system. Stakeholders said that a good number of medical professionals have clear guidance on how to recognize and work with victims of GBV/CRSV. However, problems are still reported in terms of identification of low number of GBV/CRSV victims as such in the health system. The awareness has been raised on methods to alleviate stigmatization of CRSV and GBV victims in order to ensure their better access to rights and services, and stakeholders and reports from the field have confirmed greater openness of clergy to contribute to stigma alleviation.

PD Developing of evidence-based national population policies The outcome from CPD 2010-2014 is The Government, at all levels, is able to base policies on a quantitative and qualitative analysis of disaggregated data, policy assessments and reviews, with attention focused on socially excluded groups and migrant population”. The CPD 2015-2019(2020) outcome is “Strengthened national policies and international development agenda through integration of evidence-based analysis of population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality.” The indicator for the first output is “High-quality social and demographic data integrated into policymaking processes relating to the health and social protection sectors” and for the second it is “Number of national household survey conducted that allows the estimation of key population and reproductive health”. Given the delivery of outputs evaluated above, it could be concluded that the outcomes have been partly achieved. Namely the work on migration database has not yielded results yet, but stakeholders have confirmed that there is potential to revitalize the deliverables from years before and ensure good quality data on migration and its exchange with relevant institutions. When it comes to socially excluded groups, policies have been developed for older persons, based on the available data, but have not been adopted yet. Youth policy is in place in RS, but not in FBiH. FBiH has an SRH strategy (due to expire within a year) and RS is in the process of adopting one. It cannot be concluded beyond doubt that these policies have been based on reliable data as it is known that a reliable mechanism for collection of data on SRH has not been established in the country. A promising activity is the SRH mapping, the results of which are yet to be seen.

When it comes to the wider ICPD and SDG agendas, the country and its entities are still at initial stages of localization of these standards and targets. UNFPA is expected to contribute to creating of the evidence base through the SRH mapping, Population Situation Analysis and Population Projections, and it has advocated conducting of other surveys, e.g. MICS and DHS, but this has not materialized due to a lack of donors to fund such initiatives.

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<p><u>EQ3.B Assumption 2: Assumes that the majority of progress on intended outputs can be attributed to UNFPA CP. It is unlikely that all progress towards outputs can be attributed to a given intervention.</u></p>	<p>1. Evidence of pertinent program activity in allied non-UNFPA CP program areas.</p>	<p>Review of non-UNFPA program activities and trends on context for UNFPA CP activities.</p>	<p>1. Document review, 2. Stakeholder interviews, 3. Site visits, 4. Training follow-up and client/beneficiary interviews.</p>

EQ3.B Assumption 2:

SRHR UNFPA has been the sole assistance provider among donor and development agencies in the areas of Family Planning repositioning, drafting of Clinical Guidelines, while the BtN methodology was actually created by WHO but UNFPA was in charge of rolling it out in BiH. For this reason, the majority of progress on intended outputs can be attributed to UNFPA CP.

YOUTH UNFPA has not been the sole assistance provider among donor and development agencies in the areas of Youth and Adolescents and pertinent activities. Most notably, UNFPA's contribution to the drafting of the FBIH Youth Strategy constituted only a smaller portion of a larger project funded by the EU and implemented by KULT and OKC. Also, in the area of CSE, UNFPA's has followed up on Association XY's previous work in Sarajevo Canton, but the effects in Bosnian Podrinje Canton could be attributed largely to UNFPA CP. Moreover the intervention related to theatre plays on early marriages has been delivered in cooperation with UNICEF.

GE Although UNFPA is a partner on the Joint Programme with three other agencies, UNFPA has been the sole assistance provider in the areas of health sector's response to GBV/CRSV and alleviating stigmatization. For this reason, the majority of progress on intended outputs can be attributed to UNFPA CP.

PD UNFPA has been the sole assistance provider among donor and development agencies in the areas of support for older persons. When it comes to work on the migration database, this work had been done under the YERP project, in which UNDP also participated. The promotion of SDGs has been done alongside other UN agencies, primarily the UNDP/RCO, while the advocacy for MICS has been done together with UNICEF.

EFFECTIVENESS (THIS QUESTION APPLIES TO ALL FOUR FOCUS AREAS; BUT PRIMARILY TO SRH)

EQ 4 To what extent has UNFPA contributed to an improved emergency preparedness in BiH, The Republic of North Macedonia, the Republic of Serbia, and Kosovo, and in the area of maternal health / sexual and reproductive health including MISP?

EQ4.A To what extent has UNFPA contributed to an improved emergency preparedness?

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ4.A Assumption 1: There is an emergency preparedness plan, which is complete and updated.</u>	1. Level of UNFPA contribution to emergency preparedness plan.	Stakeholders at National and sub-national level. Available data on emergency preparedness.	1. Document Review, 2. Stakeholder interviews.

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

There is no single emergency preparedness plan in BiH, but individual entities have their own individual policies on responding to emergencies.

EQ4.B Has UNFPA contributed to preparedness for MISP?

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ4.B Assumption 1: UNFPA has contributed to MISP preparedness.</u>	1. Level of UNFPA contribution to MISP	Stakeholders at National and sub-national level. Available data on emergency preparedness.	1. Document Review, 2. Stakeholder interviews.
<p>EQ4.B Assumption 1: Findings including analysis for all pertinent program areas: 1. Sexual and Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD, but primarily to SRH</p> <p>SRHR, GE UNFPA had organized MISP TOT for national participants already in 2013, along with sharing good practices and lessons learned among the countries/territory in the EECA region and adopting the action plan for the entire region on how to further integrate MISP in the national preparedness plans as part of South-South cooperation. In 2014, MISP training was conducted for key stakeholders at different levels in BiH. An assessment of national capacity level to implement MISP has been conducted and action plan has been developed, according to 2014 Annual Report. In 2017, the MISP Working Group has completed initial MISP readiness assessment for Bosnia and Herzegovina that shows elevated need for continuous support to health authorities in preparation for emergency situations. In 2017, capacities of 45 institutional representatives (primary health care centres, civil protection, police, centres for social welfare, NGOs and municipal authorities) were built on MISP and Clinical Management of Rape, including overcoming the lack of adequate services for victims of sexual violence, insufficient services for prevention and treatment of STIs, as well as unmet needs for family planning. According to stakeholders, MISP had to be adapted to the local context, but is currently a recognizable instrument. There is an informal MISP working group coordinated by the BiH Ministry of Civil Affairs and gathering representatives from the whole country. However, as a national emergency preparedness plan does not exist, MISP could not be integrated. Instead, MISP was integrated into RS SRH Strategy, and there is potential for similar integration in FBiH's emergency policies through the FBiH Ministry of Health. It can be concluded that relevant authorities in BiH can now resort to MISP as a resource in response to emergencies.</p> <p>YOUTH, PD n/a</p>			
Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ4.B Assumption 2 : The activities and outputs have contributed to a measurable and meaningful extent to the achievement pertinent to emergency preparedness, maternal health and SRH including MISP.</u>	<ol style="list-style-type: none"> 1. Pertinent indicators from CP Planning and Tracking Tool for output and outcome specific programme components pertinent to emergency preparedness, maternal health and SRH, including MISP. 2. Stakeholder qualitative perceptions on impact of activities and pertinent output impact on outcomes. 	<ol style="list-style-type: none"> 1. Key stakeholders 2. Client beneficiaries 3. AWP's, 4. COARs, 5. National, Regional quantitative data 6. UNCT progress reports 	<ol style="list-style-type: none"> 1. Document Review 2. Stakeholder interviews within pertinent programme components, 3. Interviews and FGDs. 4. Secondary data analysis. <p>(NB: The above for each of the pertinent areas).</p>

	3. Client/beneficiary qualitative perceptions on impact of activities and output impacts on outcomes (It is acknowledged that that there is no direct UNFPA work with beneficiaries.)		
<p>EQ4.B Assumption 2:</p> <p>SRHR During and after the 2014 floods, UNFPA was able to quickly mobilize 96,300.00 USD from UNFPA Emergency Response Fund for response to the priority needs of affected communities within a short time frame, as well as 300,000.00 EUR for recovery purposes. According to stakeholders, MISP was applied during the floods. UNFPA support included, among others, the rapid post floods assessment of PH facilities; the provision of RH kits and hygiene kits for older persons, vulnerable population as well as for overall population.</p> <p>GE According to COARs and stakeholders, UNFPA was very quick to respond to the migrant crisis that emerged in 2018 by deploying a specialist for GBV in emergencies to the field in Una-Sana Canton. This was preceded by a rapid assessment, which greatly informed future actions by specialists in the field. The specialists drafted Standard operating procedures (SOPs) for treatment of gender-based violence (GBV) victims in cooperation with the Una-Sana Canton Ministry of Health and Social Policy, delivered trainings and awareness raising activities for humanitarian workers and other frontline workers, established safe spaces for women and one youth centre, and organized daily activities tailored to the needs of female migrants and their cultural and other needs. In order to make this work sustainable, the SOPs have been reviewed by local experts and are expected to be adopted by cantonal authorities. SOPs have been drafted to apply to other emergency situations, not only the particular migrant crisis. At the same time, the need for a full rollout and integration of MISP across the country and relevant medical institutions remains relevant. Stakeholders have stressed that only continued work with authorities on MISP integration can guarantee relevant SRH and GBV supplies and services in emergencies.</p> <p>YOUTH, PD n/a</p>			
<p>EFFECTIVENESS (THIS QUESTION APPLIES TO ALL FOUR FOCUS AREAS; BUT PRIMARILY TO SRH, YOUTH AND GE)</p>			
<p>EQ5 To what extent has each office been able to respond to emergency situations in its Area of Responsibility (AoR), if one was declared? What was the quality and timeliness of the response?</p>			
<p><i>Comment(s) on this question:</i></p> <ul style="list-style-type: none"> • This refers to all types of emergencies, not just GBV. Therefore, the interpretation needs to allow for a wider interpretation of this question, beyond GBV. • The term AoR has been primarily focused on UNFPA leadership related to Gender-Based Violence Area of Responsibility (GBV AoR). UNFPA has been the sole lead for GBV AoR since 2016. 			
<p><i>EQ5.A To what extent has each office been able to respond to emergency situations in its Area of Responsibility (AoR), if one was declared?</i></p>			
Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection

<p><u>EQ5.A Assumption 1: UNFPA is able to respond to emergency situations if they are declared.</u></p>	<p>1. Measures of UNFPA emergency response preparedness.</p>	<p>1. UNFPA and UNDAF documents. 2. Government ministry documents pertaining to emergency response. 3. UNFPA, UNDAF and Government staff familiar with emergency response.</p>	<p>1. Document review and 2. Stakeholder interviews</p>
<p>EQ5.A Assumption 1: Findings including analysis for all pertinent program areas, but primarily to SRH, Youth and GE</p> <p>SRHR, GE During and after the 2014 floods, UNFPA was able to quickly mobilize 96,300.00 USD from UNFPA Emergency Response Fund for response to the priority needs of affected communities within a short time frame, as well as 300,000.00 EUR for recovery purposes. According to stakeholders, MISP was applied during the floods. UNFPA support included, among others, the rapid post floods assessment of PH facilities; the provision of RH kits and hygiene kits for older persons, vulnerable population as well as for overall population.</p> <p>UNFPA was very quick to respond to the migrant crisis that emerged in 2018 by deploying a specialist for GBV in emergencies to the field in Una-Sana Canton.</p>			
<p><i>EQ5.B What was the quality and timeliness of the response?</i></p>			
<p>Assumption to be assessed</p>	<p>Indicator/Criteria</p>	<p>Source of information</p>	<p>Method and tools for data collection</p>
<p><u>EQ5.B Assumption 1: If UNFPA was asked to respond to an emergency situation, it responded with quality and in a timely fashion.</u></p>	<p>1. Evidence of the nature of a UNFPA response to an emergency situation.</p>	<p>1. UNFPA and UNDAF documents. 2. Government ministry documents pertaining to emergency response. 3. UNFPA, UNDAF and Government staff familiar with emergency response.</p>	<p>1. Document review and 2. Stakeholder interviews.</p>
<p>EQ5.B Assumption 1: Findings including analysis for all pertinent program areas, but primarily to SRH, Youth and GE</p> <p>SRHR Majority of stakeholders said that UNFPA responded with quality and in a timely fashion to emergency during and after May 2014 floods. Some delays were reported in delivery of mobile health units. Also stakeholders reported that UNFPA was very quick to respond to migrant crisis by deploying a GBV specialist to the field in Una-Sana Canton and developing procedures and training for frontline people and reception on GBV, SRH, psychosocial support, safe spaces, etc.</p> <p>GE According to COARs and stakeholders, UNFPA was very quick to respond to the migrant crisis that emerged in 2018 by deploying a specialist for GBV in emergencies to the field in Una-Sana Canton. This was preceded by a rapid assessment, which greatly informed future actions by a specialist in the field. The specialist drafted Standard operating procedures (SOPs) for treatment of gender-based violence (GBV) victims in cooperation with the Una-Sana Canton Ministry of Health and Social Policy, delivered trainings and awareness raising activities for humanitarian workers and other frontline workers, established safe spaces for women and one youth</p>			

centre, and organized daily activities tailored to the needs of female migrants and their cultural and other needs. In order to make this work sustainable, the SOPs have been reviewed by local experts and are expected to be adopted by cantonal authorities. SOPs have been drafted to apply to other emergency situations, not only the particular migrant crisis. At the same time, the need for a full rollout and integration of MISP across the country and relevant medical institutions remains relevant. Stakeholders have stressed that only continued work with authorities on MISP integration can guarantee relevant SRH and GBV supplies and services in emergencies.

YOUTH, PD n/a

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

EQ5.B Assumption 2:

As above

EFFICIENCY (APPLIES TO ALL FOUR FOCUS AREAS)

EQ6.To what extent has UNFPA made good use of its human, financial and technical resources, and has used an appropriate combination of tools and approaches to pursue the achievement of the results defined in the UNFPA programme documents?

Comment(s) on above question:

- There is an inherent subjectivity to the definition and measurement of what is “good use” of resources.

EQ6.A To what extent has UNFPA made good use of its human, financial and technical resources to pursue the achievement of the results defined in the UNFPA programme documents?

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<p><u>EQ6.A Assumption 1: UNFPA has made good use of its human, financial and technical resources to pursue the achievement of results defined in UNFPA programme documents.</u></p>	<p>1. Amount of resources used to achieve the outputs/outcomes, compared to the value of achieved outputs.</p>	<p>1. Key stakeholders; 2. Documentation of programme inputs by category (human, financial, technical).</p>	<p>1. Key stakeholder interviews 2. Document review 3. Budget review.</p>

	<ol style="list-style-type: none"> 2. The planned inputs and resources were received as set out in the AWP's and agreements with partners. 3. The resources were received in a timely manner according to timeline set in the agreement. 4. Inefficiencies were corrected as soon as identified. 5. Trend analysis: Implementation rate, Distribution by sector/outcome 6. Access of internal or external human/technical resources to enhance programme effectiveness 7. Timely and quality TA provisions 	<ol style="list-style-type: none"> 3. Feedback on quantity and quality of TA provided to implementing agencies. 4. Atlas data. 	
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EQ6.A Assumption 1: Findings including analysis for all pertinent program areas

SRHR Analysis of the budgets allocated for selected activities in this programme area for the period 2013-2018 found that around 517,000 USD was allocated for these activities, excluding the costs of UNFPA SRH staff and activities out of the sample. The allocated percentage of the total yearly budgets for interventions in this programme area has ranged from 7 to 27 percent of the overall budget. The budget utilization rate has been around 100 percent for this component of the programme. There is evidence of consistency in the planning of budgets for specific interventions and expenditures, which demonstrates exceptional budgetary discipline, according to annual financial reports.

Over the period 2013-2018, the SRH component in UNFPA CO has been led by several people, with support of the CO leadership and support staff. Generally one technical staff is in charge of one programme area. Interviewed stakeholders noted a high turnover of staff on this component of the UNFPA CP. It was confirmed by several interviewees that the job market for SRH specialists was rather small in BiH, which impeded the process of recruitment of qualified staff by the UNFPA. Some interviewees said that the recruitment requirements for this component were too demanding for the limited market in BiH. On the other hand, it was noted by a majority of stakeholders interviewed that UNFPA has managed to recruit SRH specialists as international, regional, or local consultants, who added value to the execution of activities, such as drafting of the SRH strategy in RS, building local capacities for drafting of clinical guidelines in line with international standards and comparative best practices, introducing maternal death surveillance, rolling out family planning in primary health care, and so on. Stakeholders also generally praised the UNFPA CO leadership for ensuring greater and maintaining consistent focus on the area of SRH. In this component, as well as others, the UNFPA presence in Banja Luka through a designated half time

member of staff has been welcomed due to achieved focus and closer communication in everyday activities. It was recommended that this support be extended to even greater presence in RS.

Due to its business model and lack of human resources, CO in BiH has been delivering activities through its implementing partners. In the area of SRH, two key partners have been engaged. PPH has been in charge of rolling out several deliverables, including Family Planning repositions, drafting of clinical guidelines, facilitating maternal death surveillance, and integrating MISP into emergency preparedness, among other activities. XY has been in charge of facilitating drafting of SRH strategies in RS and FBiH, as well as individual advocacy activities. The capacities of implementing partners to deliver UNFPA interventions could not be assessed fully as part of this evaluation. Stakeholders have generally welcomed their assistance and good working relationships. On the other hand, the funds allocated to implementing partners have not been excessive, ranging from 8 to 44 percent of the budgets allocated for activities in the sample over the years. Given the results achieved, as outlined assessed above under Effectiveness, it could be concluded that the capacity of implementing partners was sufficient to absorb these funds and deliver required activities. In the stakeholder interviews, there was no evidence of inefficient spending of funds through implementing partners.

UNFPA in BiH generally has a small programme and limited funds. Some stakeholders said that it was difficult to raise funds for interventions in the SRH programme area as there seemed to be insufficient donor interest in this area. More aggressive fundraising has been suggested by some stakeholders. There is evidence of CO's efforts to raise funds in Resource Mobilization Strategies. However, mobilization of donors for implementation of Demographic and Health Survey does not seem to have yielded results. There are efforts to raise funds for implementation of MICS6 together with UNICEF, as well as a joint proposal for DRR project with UNDP, UNICEF, UNESCO and FAO.

YOUTH Analysis of the budgets allocated for selected activities in this programme area for the period 2013-2018 found that around 240,000 USD was allocated for these activities, excluding the costs of UNFPA SRH/Youth staff, other costs and activities out of the sample. The allocated percentage of the total yearly budgets for interventions in this programme area has ranged from 2 to 15 percent of the overall budget. In the years when 15 and 13 percent of the budget was allocated to this component (2014 and 2015 respectively), the biggest amount of funds was actually spent on MISP in 2014 and YSRH staff salary and rent in 2015. In other years, the percentage of budget allocated and spent on this component ranged from 2 to 5 percent. The overall utilization rate for this component has been at 92% . There is no full consistency in the planning of budgets from year to year. For example, the planned budget increased by four times in 2014 in relation to 2013 and by three times in 2015 in relation to 2013, in order to drop to 1/7 of the 2015 budget in 2016 and remain unstable for two consequent years. The spending in 2014 and 2015 could be explained by the emergency situation caused by floods in BiH.

Over the period 2013-2018, the YOUTH component in UNFPA CO has also experienced changes of staff, which, according to stakeholders required some adjustment time. It was noted by stakeholders that UNFPA needed to have more staff, if they are willing to work across a number of intervention areas, including youth and adolescents. UNFPA has selected relevant partners for delivery of activities, with proved ability and track record in delivering youth-related interventions related to policy, participation, or education, in line with its Resource Mobilization Plans. It could be argued that some implementing partners could have absorbed even greater budget allocations for expansion or rollout of initiatives.

Only a small portion of UNFPA's budget has been spent on the component of Youth and Adolescents. Given the number and reach of activities, it can be argued that the activities were generally contributing to achieving the outcome. However, the COARs and financial reports indicate that UNFPA was struggling among competing priorities and able only to allocate funds for isolated, rather than systemic activities, e.g. having to focus on one canton for integration of CSE, instead of aiming to replicate this

policy and practice even further, or organizing one off theatre plays on early marriages in absence of funds for more systemic response to the issue. On the other hand, systemic efforts to develop youth policies have been praise worthy, but proved to be at risk of political will, at least in FBIH. On the other hand, with the exception of the 2015 Resource Mobilization Plan, which demonstrates an ambitious approach to mobilizing funds for Youth and SRH, youth policies, and work with marginalized groups, subsequent RMPs focus on mobilization of funds for DHS or MICSSs (which cover other target groups apart from youth) and some new areas of intervention such as youth, peace and security.

GE Analysis of the budgets allocated for selected activities in this programme area for the period 2013-2018 found that around 540,000 USD was allocated for these activities, excluding the costs of UNFPA GE staff, other costs and activities out of the sample. The allocated percentage of the total yearly budgets for interventions in this programme area has ranged from 12 to 28 percent of the overall budget. In 2014, the lowest 12 percent was allocated, which strikes as a difference in relation to all other years when on average 26 percent of the budget was allocated to this component. This difference could be attributed to lack of donor funds in 2014. There is no full consistency in the planning of budgets from year to year, with the budgets decreasing or increasing by roughly 100,000 to 150,000 USD between years. The execution of budgets ranged from 87 to 100 percent. The biggest amounts were spent on health sector's response to GBV, followed by stigma alleviation activities, and gender transformative actions.

Over the period 2013-2018, the GE component in UNFPA CO has experienced changes of staff, but retained institutional memory. It was noted by stakeholders that UNFPA had low budgets and needed more staff, if they are willing to work across a number of intervention areas. Otherwise they should plan their interventions more realistically. UNFPA has worked a number of partners in delivery of activities (up to 10), mostly from the NGO sector (although this is not reflected in the partnership plans), and this has inevitably put additional pressure on the UNFPA to manage these partnerships and delivery. When it comes to specific expertise for GBV and CRSV, it was assessed as sufficient, particularly having in mind close relationships with relevant professionals from BiH's public sector who were engaged in delivery of activities. However, given the number of activities under this component, it could be argued that the UNFPA office resources have been spread too thin, as confirmed by stakeholders. This is particularly given the pressure of spending on delivery of outputs with delayed donor payment due to different financial schedules.

The biggest portion of UNFPA's budget has been spent on this component (roughly one quarter). This is a result of additional donor funding for this component, given donor's interest in CRSV. Given the number and reach of activities, it can be argued that the activities were generally contributing to achieving the desired outcome. However, the COARs and financial reports indicate that UNFPA was struggling to bring delivery to successful finalization over several years. For example, the work on health sector's response to GBV, as embodied in production of the resource package and delivery of training, has extended over five years, taking half of the budget spent on selected directed activities. The results match the funds invested, but the time invested show slow dynamics. Also, significant funds have been invested in the Masculinity Study, while its effects have not necessarily materialized. Stigma alleviation spending is the second biggest in this component, and this deliverable has been very visible and praised by stakeholders, although the effects are yet to be measured.

PD Analysis of the budgets allocated for selected activities in this programme area for the period 2013-2018 found that around 234,791.92 USD was spent on selected PD activities, excluding the costs of UNFPA staff and activities out of the sample. The allocated percentage of the total yearly budgets for interventions in this programme area has ranged from 6 to 18 percent of the overall budget, but on average at 10 per cent. The budget utilization rate has been around 100 percent for this component of the programme. There is evidence of consistency in the planning of budgets for specific interventions and expenditures, which demonstrates exceptional budgetary discipline, according to annual financial reports.

Over the period 2013-2018, the PD component in UNFPA CO also experienced changes of staff, but a smooth transition. One technical staff is in charge of this programme area, but this member of staff is also in charge of monitoring and evaluation for the CP. By the nature of his job, this member of staff has been involved in the work of other components too, particularly in the areas of policy drafting and development of results frameworks. However, this component of CP has focused on the work related to older persons, according to COARs and financial reports, while very little resources have been allocated for data collection, advocacy of provision of sound and reliable data by relevant authorities in BiH, and developed of evidence-based population policies, which feature predominantly in UNFPA strategic plans and CPDs. There is evidence in Resource Mobilization Plans of efforts to raise funds for several surveys, including the Population Situation Analysis, Population Projections, MICS6 and DHS.

CO in BiH has been delivering activities through an implementing partner - the PPH, which has been involving largely in establishment and development of Centres for Healthy Ageing. This partner has demonstrated capacities for this work, given its know-how and long standing experience in work with Healthy Ageing Centres.

Still the overall budget for this component, which could be considered the core and overarching component of UNFPA globally and in BiH, has been very tight, which prevented the CO in engaging in more ambitious data collection activities and capacity building for evidence-based development of population policies. More specifically, in the period under evaluation CO has not been able to deliver a single population survey or other reliable data collection effort on any of the pertinent issues. Some activities are planned for 2019, including the Population Situation Analysis and the Population Projections, which is promising. The absorption capacities of partner institutions, i.e. the statistical agencies is a constraining factor, which has made CO's advocacy activities less effective.

EQ6.B To what extent has UNFPA used an appropriate combination of tools and approaches to pursue the achievement of the results defined in the UNFPA programme documents?

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ6.B Assumption 1: UNFPA has used an appropriate combination of tools and approaches to pursue the achievement of the results defined in the UNFPA programme documents.</u>	1. Amount of human, financial and technical tools and approaches used to achieve the outputs/outcomes, compared to the results achieved in outputs/outcomes.	1. Key stakeholders; 2. Documentation of programme inputs by category (human, financial, technical). 3. Feedback on quantity and quality of TA provided to implementing agencies. 4. Atlas data.	1. Key stakeholder interviews, 2. Document review, 3. Budget review.

EQ6.B Assumption 1: Findings including analysis for all pertinent program areas

SRHR From the budget review, it could be concluded that a good share of funds for selected activities was spent on technical expertise provided by individual experts. Also, from annual reports and interviews with stakeholders, it is clear that UNFPA has been using global and international documents and tools, adjusting them to BiH context with help of international and local consultants, and training local professionals to replicate knowledge gained. The evidence for this could be found in almost all

selected interventions assessed under effectiveness above. Namely, family planning repositioning, clinical guidelines, maternal death surveillance, MISP, have all been based on internationally designed methodologies that have been replicated in BiH.

YOUTH From the budget review, it could be concluded that a good share of funds for selected activities was spent on technical expertise provided by individual experts. Also, from annual reports and interviews with stakeholders, it is clear that UNFPA has been reviewing local policies and practices to align them with international standards (e.g. CSE curriculum review, methodological support to youth policy development). Also, UNFPA has been innovative, together with UNICEF, in organizing theatre plays on early marriages as a youth-friendly approach to at-risk groups. Stakeholders and training participants have praised the approach taken to delivering of CSE training to primary school teachers in the Bosnian Podrinje Canton.

GE From the annual reports and interviews with stakeholders, it is clear that UNFPA has been using global and international documents and tools, adjusting them to BiH context to localize standards for health sector’s response to GBV. There is evidence of this in development of the resource package for response to GBV generally and in crisis. Also, UNFPA has been innovative in activities related to stigma alleviation and gender transformative actions. This is demonstrated by the theatre plays for reducing stigma against CRSV victims, work with IRC as until then a non-traditional partner, and by supporting BiH’s Woman’s Football Club. The latter resulted in greater visibility of women’s football in BiH, by attracting new fans, as well as development of Football Team’s capacities to promote women’s football, seek funds and equality of treatment of women football players, thus breaking away from traditional gender norms.

PD From the budget review, it could be concluded that most activity funds have been spent on Healthy Ageing Centres, where the knowhow of the implementing partner has been used efficiently.

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<p><u>EQ6.B Assumption 2: UNFPA CPs have expended resources to achieve outputs at a level that is consistent with standard norms for the cost of implementing program activities in each of the four program areas.</u></p>	<p>1. Amount of resources used to achieve the activities, outputs as compared to the standard norms for the cost of achieved outputs.</p>	<p>1. Key stakeholders; 2. Documentation of programme inputs by category (human, financial, technical). 3. Feedback on quantity and quality of TA provided to implementing agencies. 4. Atlas data. 5. COARs 6. IP reporting data. Training data.</p>	<p>1.Key stakeholder interviews, 2.Document review 3.Budget review of sentinel activities vs budget in AWP. (NB: The above for each of the four program areas).</p>

EQ6.B Assumption 2:

SRHR The following table illustrates UNFPA’s spending on SRH from the total budget by years.

	2013	2014	2015	2016	2017	2018
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allocated SRH	77.737	377.415	177.579	241.385	194.839	237.854
spending SRH	75.172	376.057	174.311	236.729	194.545	235.965

This overview includes staff costs and direct recovery funds (in 2014).

	2013	2014	2015	2016	2017	2018	
Emergency response and integrating MISP		244.926	3.584	40.371	30.430	119.939	
Maternal health, including cervical and breast cancer	34.914	22.693	15.843	16.648	31.507	17.173	
Family Planning repositioning	19.003	11.658	58.547	29.914	13.380	8.629	
SRH strategies		18.453	7.655	11.227	21.170	13.098	
Promote ICPD and SDGs in BiH					3.157	15.691	
Total activities	55929,51	297.730	85.629	98.159	99.644	176.548	813.64
Personnel costs	38.995	71.430	80.002	91.868	76.630	110.961	

YOUTH The following table illustrates UNFPA's spending on YOUTH and ADOLESCENTS from the total budget by years.

	2013	2014	2015	2016	2017	2018
allocated Youth	50.862	217.103	155.886	21.400	37.735	74.859
spending Youth	49.146	215.492	150.265	20.181	37.812	73.883

This overview includes staff costs and direct recovery funds (in 2014).

	2013	2014	2015	2016	2017	2018	
youth policies		7.907	51.336	2.515	15.667	1.661	
CSE		25.739	6.136	9.359	5.936	22.388	
Y-Peer clubs	19.436	37.341					
early marriage			1.481	5.743	10.686		
youth friendly approaches						8.577	
youth programming						10.629	
Total activities	19435,62	70.986	58.953	17.618	32.290	43.254	242.537
Personnel costs	28.902	54.939	78.341	324	3.155	0	

GE The following table illustrates UNFPA's spending on GE from the total budget by years.

	2013	2014	2015	2016	2017	2018
allocated GE	251.194	167.378	324.750	276.930	238.033	318.202
spending GE	218.787	167.928	327.128	263.474	219.697	190.028

This overview includes staff costs.

	2013	2014	2015	2016	2017	2018	
HEALTH CARE RESPONSE		27.329	97.864	67.035	40.002	26.882	
STIGMA ALLEVIATION					68.168	63.906	
GENDER TRANSFORMATIVE ACTIONS			53.528	24.030	3.227		
DEVELOPING STRATEGIES	10.385	63.648					
self help			39.963		9.546	4.783	
Total activities	10384,99	90.977	191.354	91.065	120.944	95.571	600.296
Personnel costs	80.307	67.388	64.246	58.347	49.080	63.607	

PD The following table illustrates UNFPA's spending on PD from the total budget by years.

	2013	2014	2015	2016	2017	2018
allocated PD	108.372	249.241	115.631	105.232	107.218	145.023
spending PD	108.263	245.080	110.549	101.101	107.023	144.564

This overview includes staff costs.

	2013	2014	2015	2016	2017	2018	
MIGRATION		29.558					
POLICIES, DATA COLLECTION	3.833	3.148	11.594	3.837	2.313	13.438	
HAC		102.636	28.860	16.460	14.858	4.255	
Total activities	3833,34	135.343	40454,03	20297,13	17171,38	17693,03	234791,92
Personnel costs	97.462	99.000	66.162	66.758	86.607	95.448	

SUSTAINABILITY (APPLIES TO ALL FOUR FOCUS AREAS)

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

Comment(s) on above question:

- For the purpose of this work, it is assumed that programme results are sustainable (short-term refers to up to three years, long-term is greater than three years.) Short-term and long term are somewhat subjective in nature and require a combination of qualitative and quantitative indicators to measure. Each can be addressed with a combination of quantitative and qualitative assessment approaches.

Comment(s) on indicators for above question:

- Short-term sustainability*
 - Short-term ability of institutions to continue functions without external support.
 - Measures of capacity building, esp. training activities.
 - Measures of ownership: Patterns of staffing turnover
 - Counterpart agency sources of budget, current and future.
- Long-term sustainability* can be measured quantitatively via the level of fund-raising or cost-sharing achieved by a UNFPA donor recipient has achieved for a given activity. Qualitatively, stakeholders provide their subjective impressions on the buy-in, ownership and institutional commitment of a UNFPA donor recipient to continue a given program activity in the absence of future UNFPA support.

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
EQ7 Assumption 1: The UNFPA CP has supported programs that have results that can be sustained in the short- and long-term (up to three years and greater than three years) in each of the four program areas.	<ol style="list-style-type: none"> Short-term and long-term ability of institutions to continue functions without external support. Measures of capacity building, esp. training activities that endure for short versus long-term. Patterns of staffing turnover Counterpart agency sources of budget over time. 	<ol style="list-style-type: none"> CCA 2015 UNFPA CP COARs, AWP, s, Implementing agency reports. Training data. Stakeholders in management positions within Ministry and IPs Client beneficiaries. 	<ol style="list-style-type: none"> Key stakeholder interviews, Training follow-up interviews Client/beneficiary interviews Document review Budget review. <p>(NB: The above for each of the four program areas).</p>

EQ7 Assumption 1:

SRHR All interventions in this programme area have potential of being sustainable in the short term and long term. This is because either policies were developed (e.g. RS SRH Strategy), guidelines made and disseminated (e.g. PPH and eclampsia guidelines), instruments and methodologies were established (e.g. MISP, maternal mortality surveillance), or trainings were conducted (e.g. family planning repositioning). However, sustainability has not been ensured for every intervention and every result equally, so their sustainability remains subject to follow up activities either by UNFPA, or local beneficiaries. The following are some examples where sustainability could be expected.

- RS SRH Strategy is expected to be sustainable in the long term as it covers the period of 10 years, it was drafted by local stakeholders with confirmed commitment of RS authorities. The ownership of this policy is guaranteed. There are key assumptions for implementation of this comprehensive documents, including an action plan for implementation, monitoring indicators, and a costing plan. There is some skepticism among stakeholders that policies in the area of SRH will be consistently implemented, for at least two reasons: SRH is not a priority government policy, and sufficiency of funds allocated for implementation of policies is questionable as budgets are rarely allocated specifically for this specific policy.
- Family planning repositioning could have potential for sustainability given that knowledge has been transferred to a large number of primary health care doctors. However, it is uncertain to what extent these doctors will consistently use the knowledge gained, as this could depend on personal choices, affinities, and enthusiasm. Some sustainability measures have been ensured by integrating family planning into quality standards for family medicine in FBiH, while the same is yet to be done by the accreditation institution in RS. Moreover, although it is clear that the awareness of primary health care doctors on family planning has been raised, it is hard to expect that their counseling will be guaranteed unless family planning is a part of continuous training of family doctors, unless there are clear and visible procedures for counseling, and unless procedures and results of counseling are regularly monitored and periodically evaluated, with recommendations for actions for improvement. Further more, it is hard to imagine sustainability and effectiveness of family planning counseling without access to affordable contraceptives, which has not been achieved in BiH.
- Concerning maternal health, clinical guidelines that have been developed and disseminated are a lasting resource. Both FBiH and RS accreditation agencies stand by the clinical guidelines and have participated in their development, together with other local professionals, who have been trained as a group to draft clinical guidelines. Ownership and use of the guidelines are likely to be sustained, as according to stakeholders, they protect practitioners from mistakes. Further sustainability could be ensured should further promotion and dissemination of guidelines, particularly for eclampsia, as these guidelines are expected to be applied by a wider spectrum of doctors, not only gynecologists. According to stakeholders, training on application of guidelines is not necessary as they expected to be applied by incumbent practitioners. One particular activity did not demonstrate sustainability, and that is the intervention exploring options for cervical and breast cancer screening. Although promising in 2013, this activity was not followed up, while the interviewed stakeholders said that options should be analysed for introduction of systemic and regular screening among women and men for cervical, breast and prostate cancer
- The maternal mortality surveillance system is still in nascent phase in BiH, and it is not certain what the future piloting in FBiH and RS clinics will show. Because the system has not been established in BiH yet, it is not possible to assess its sustainability. The first step remains ensuring commitment of authorities in FBiH and RS to and ownership of maternal mortality surveillance system.
- MISP has not been integrated into emergency preparedness plans, but MISP procedures have been developed and the Health ministries can avail themselves of this resource in case of emergency. There are trainers for MISP as a lasting resource, as well as an informal working group coordinated by the BiH Ministry of Civil Affairs which developed a MISP Readiness Action Plan 2019-2021, indicating three-year sustainability. However, more remains to be done to integrate MISP into emergency preparedness plans across BiH.

One noteworthy observation gained through this evaluation is a low turnover of staff in relevant institutions in the SRH. The fact that generally the same individuals have been incumbent in important policy positions in the Health ministries, accreditation agencies, and even relevant CSOs (including the implementing partners and associations of physicians) for a number of years contributes to institutional memory, continuity of actions and interventions, and general availability for follow up in order to ensure sustainability of actions in the SRH area.

YOUTH Prospects of sustainability of interventions in this programme area vary.

The policy development is expected to be sustainable in the short term with the passage of the RS Youth Policy 2016-2020, but there are reservations toward this given that the policy has not been costed and budget funds have not been allowed. On the other hand, the fact that the FBiH Youth Strategy was not adopted because of failure to obtain a positive opinion of the FBiH Ministry of Finance indicates lack of even short-term sustainability of this intervention.

When it comes to theatre plays for early marriages, this intervention does not show prospects of short-term or long-term sustainability. As argued earlier, this initiative certainly raised awareness, but there are no guarantee that the awareness will be further raised and prevented in order to contribute to actual delay of early marriages.

A distinction should be made between peer education clubs and integration of CSE into school curricula. UNFPA noted in one of its COARs that peer education clubs organized by NGOs did not guarantee sustainability because the education was not formalized through public sector institutions. On the other hand, the fact that Healthy Lifestyles and Youth Health subjects, which have been integrated into primary school curricula in Sarajevo and Bosnian Podrinje Cantons indicates good prospects of at least short-term sustainability. Longer-term sustainability could be ensured provided further actions. More specifically, the Healthy Lifestyle subject has been integrated into school curricula in the Sarajevo Canton since 2012. However, because it was not made mandatory, the stakeholders interviewed have reported dropping numbers of students choosing to attend these classes. This is an example of lessons learned, which was addressed in the Bosnian Podrinje Canton. Sarajevo Canton has not done an evaluation of the programme, but has received feedback that it is still required to work with school managements and pedagogues to support the subject. On the other hand, in Bosnian Podrinje Canton, the Youth Health subject has been made compulsory and shows better prospects of sustainability. There is strong commitment and obligation of the education authorities to review the school curricula annually and review reports on delivery of this subject. Also, there is an expressed need to extend the subject to secondary schools, and to lower grades of primary school in an adjusted form, as well as to train new teachers to ensure that turnover of staff is not an obstacle to fully embedding this subject. The sustainability of current classes delivery has been ensured by the commitment of education authorities and relevant educational materials, over which the education authorities hold full ownership. However, it is uncertain when cantonal authorities will allocate funds for expansion of this success.

GE Some interventions in this programme area have potential of being sustainable in the short term and long term. This is because either policies or procedures were developed and endorsed and training was delivered (e.g. resource package for health sector's response to GBV). Other interventions show poorer prospects of sustainability as they introduced controversial practices that require further support to become mainstreamed into institutional and legal systems and have lasting effects.

When it comes to work related to health sector's response to GBV, the fact that the resource package was created in close cooperation with line ministries, that training of trainers was delivered and a group of trainers secured as a lasting resource in the form of local professions, the fact that training was delivered to a large number of professionals, all contribute to the likelihood of sustainability of these actions. Stakeholders have confirmed ownership of these interventions by relevant ministries. On top of this, sustainability is guaranteed by the already existing policy framework in RS and FBiH pertaining to treatment of GBV victims and perpetrators (laws, bylaws, strategies, international obligations). Operating procedures for work with GBV victims have been formalized and embedded into regular practice of several medical centres, with potential for replication. However, the major concern is that these operating procedures have not been embedded into a greater number of medical centres. The health authorities have replication plans, but they report that further efforts need to be invested in embedding the operating procedures need to become part of everyday's work of every relevant health institution in the country. Furthermore, although a group of trainers exists in both entities, it is not certain that budgets will be approved for further training of medical professionals on health sector's response to GBV/CRSV. Namely, it was already noted that even in places where the operating procedures have been embedded, there is very low identification of GBV victims, which is incomparable with violence prevalence numbers. Apart from replication and further regulating of new practices, regular monitoring and evaluation of their implementation needs to be ensured.

Concerning activities related to stigma alleviation, it was found that these activities have largely been isolated and not embedded into policy and practices of relevant institutions. The only exception is the IRC's Declaration on Denouncing stigma against CRSV survivors and the manual produced for religious officials. However, stakeholders said that without follow up work with religious officials, the manual cannot guarantee sustainability.

Gender transformative actions in the form of Masculinity Study, for example, will not be sustainable unless followed up. The work with BiH Women's Football Team, on the other hand, shows prospects of sustainability in terms of promotion of women's football. The Football Association has hired one more person to work with the team and promote the women team's status in the Football Association and wider. It is uncertain, however, to what extent this can be attributed to UNFPA's interventions only or to UEFA's gender policies, but capacities of the Team have increased and are likely to be further utilized for advancing gender equality.

PD The prospects of sustainability of results under PD component vary to some extent. The Strategies for Improving the Status of Older Persons, when adopted by relevant authorities, could provide policy guidance on this issue for the next 10 years. However, their implementation will depend on the willingness and possibility of domestic authorities to allocate sufficient resources for implementation, as the strategic documents themselves do not contain the costing elements. When it comes to Healthy Ageing Centres, they have demonstrated prospects of sustainability by the fact that local authorities have allocated funds for their operations and maintenance. There seems to be ownership of local authorities over these centres and clients have testified about their contributions too in order to support work of these centres. At the same time, they stressed the need for renovation of older centres and continuous improvements.

When it comes to results related to migration database, from 2013, although this activity was considered suspended and without effective results in the evaluation period, there is indication that the BiH Ministry of Security will revitalize the results and will integrate the strategy for migration monitoring in line with Eurostat rules in its regular processes and exchange with the BiH Agency for Statistics in the process of reengineering of its Migration Information System, which indicates good sustainability prospects.

The CO work on evidence-based population policies, collection of relevant data and advocacy of these efforts in BiH has not been substantive enough to provide for sustainability. The constraining factors included lack of funds and absorption capacities of relevant institutions in BiH. It should be noted that the authorities in BiH have not demonstrated commitment to development of comprehensive population policies in individual parts of the country and more efforts need to be invested in raising of awareness, defining policy framework for population development and development in general, and integration of existing policies (youth, SRH, and policies on ageing) into future population policy framework.

SUSTAINABILITY (APPLIES TO ALL FOUR FOCUS AREAS)

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

Comment(s) on above question:

- Data will be collected on partnerships established by UNFPA to assess national ownership and sustainability of supported interventions, programmes, and policies. In some cases, it may be difficult to distinguish interventions from programmes and policies. The evaluation will rely in part on self-reports of partnership stakeholders, which may be biased toward making a favourable impression to donors.

Comment(s) on indicators for above question:

- Short- and long-term sustainability of UNFPA supported partner institutions to continue, replicate or adapt programme functions without external support. Measures of national ownership and sustainability in different types of interventions, programmes and policies.

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<p><u>EQ8 Assumption 1: The UNFPA CP has succeeded in developing partnerships that promote the national ownership and sustainability of supported interventions, programmes and policies.</u></p> <p>Comment on Assumption to be assessed for question. In some countries/territory it may be that there are not many partnerships that have been successfully established by UNFPA.</p>	<ol style="list-style-type: none"> 1. Short and Long-term ability of UNFPA supported partner institutions to promote national ownership and sustainability of supported interventions, programmes and policies. 2. Measures of capacity building, esp. training activities. 3. Patterns of staffing turnover and counterpart agency 4. Long-term budgeting over time (evidence of Ministry or other entity buy-in). 	<ol style="list-style-type: none"> 1. National Ministry Strategic Planning documents, 2. UNFPA CP, COARs, AWP, s, 3. Implementing agency reports. 4. Training data. 5. Stakeholders in management positions and beneficiaries. 	<ol style="list-style-type: none"> 1. Key stakeholder interviews with Senior policy makers within Ministry and IPs, 2. Document review, 3. Budget review. 4. Training follow-up interviews. <p>(NB: The above for each of the four program areas).</p>
<p>EQ8 Assumption 1:</p> <p>SRHR UNFPA has not signed formal partnership agreements with authorities in BiH. However, by signing UNDAF documents, BiH authorities have confirmed their agreement with interventions and assistance of UN agencies in BiH, including UNFPA. Moreover, stakeholder interviews have revealed a very important aspect of UNFPA planning, that is, individual yearly discussions and planning with relevant institutions on what both sides consider priority interventions. In the area of SRH, the Health authorities have been the key counterparts, but apart from them, the BiH Ministry of Civil Affairs, the RS Public Health Institute and FBIH Public Health Institute, the entity health accreditation agencies, as well as implementing partners and international associates (e.g. South-Eastern European Health Network, UNICEF, WHO) have also been recognized as the key partners in the Partnership Plans. All SRH stakeholders interviewed said that they valued their partnership and cooperation with UNFPA.</p> <p>YOUTH UNFPA has not signed formal partnership agreements with authorities in BiH in this component. However, the ownership and enthusiasm of Bosnian Podrinje Canton education authorities indicates continuous sustaining of the results achieved in CSE integration.</p> <p>GE UNFPA has not signed formal partnership agreements with authorities in BiH, but all planning has been done in cooperation with authorities. The Health Ministries take full ownership of resources developed as part of interventions related to health sector's response to GBV. Other institutions and organizations have been recognized as partners in UNFPA's Partnership Plans, including religious institutions and BiH Women's Football Team. All GE stakeholders interviewed said that they valued their partnership and cooperation with UNFPA.</p>			

PD UNFPA has not signed formal partnership agreements with authorities in BiH. However, the Partnership Plans in the PD component outline the key partners. The partnerships have been observed and confirmed during this evaluation.

COMPONENT 2: ANALYSIS OF UNFPA Country/territory Programme UNCT Cooperation and Value Added

UN COUNTRY/TERRITORY TEAM COORDINATION

EQ9 To what extent did UNFPA contribute to coordination mechanisms in the UN system at country/territory level?

Example: Results teams led or assisted by UNFPA.

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<p><u>EQ9 Assumption 1: The UNFPA CO has made consistent positive contributions to the consolidation and functioning of UNCT coordinating mechanisms (working groups and joint programs) toward implementation of the UNDAF in each of the four program areas.</u></p>	<p>Reported level of UNFPA CO staff participation in:</p> <ol style="list-style-type: none"> 1. UNCT planning and coordination functions. 2. Pertinent UNCT theme groups 3. Other UNCT administrative bodies for coordination of activities. 4. Concrete examples of UNFPA CO participation in the process of consolidation of UNCT coordination procedures and programs. 	<ol style="list-style-type: none"> 1. UNCT staff at senior management and theme group levels. 2. UNCT Theme group minutes 	<ol style="list-style-type: none"> 1. Stakeholder interviews with UNRC and members of UNCT theme groups and UN agencies. 2. Document review of coordination of joint program activities <p>(NB: The above for each of the four program areas).</p>

EQ9 Assumption 1:

The United Nations Country Team (UNCT) in Bosnia and Herzegovina is comprised of thirteen UN Funds, Programmes and Specialized Agencies (FAO, ILO, IOM, UNDP, UNFPA, UNEP, UNESCO, UNHCR, UNICEF, UNODC, UNV, UN Women, WHO), the Bretton Woods Institutions (World Bank, IMF) and ICTY. The work of the UNCT is being coordinated through the Office of the UN Resident Coordinator and framed within the One UN Programme for Bosnia and Herzegovina 2015-2019(2020) representing the strategic, programmatic and financial basis for the development partnership between the United Nations and the country/territory.

UNFPA has consistently contributed to common country planning and implementation of UNDAF. This was confirmed by analysis of UNDAF documents and implementation plans, as well as through interviews with relevant stakeholders. UNFPA is a regular and active member of most Results Groups in UNCT (not in Economic Development Results Group), under UNDAF, but stakeholders have particularly emphasized its role in the Social Inclusion Results Group, Youth Task Force, the Coordination Group for Migrant Crisis, and M&E Results Group. It was stressed in stakeholder interviews that UNFPA has consistently managed to raise its profile through

work in Results Groups, despite being a small agency. In some groups, UNFPA has had a convening role (like the M&E group), but it has initiated creating of a Youth Task Force (2017 COAR). Stakeholders from the UNCT have valued this initiative greatly.

There is evidence that UNFPA participated in the reporting of the UNCT in the period 2015-2017 (see reports), but the method of reporting has changed at the UNCT level. Namely, the latest, 2017 report, does not single out contributions of individual agencies any more, but reports on UNCT achievements as a whole.

UNCT COOPERATION

EQ10 To what extent does the UNDAF/UN Partnership Framework, reflect the interests, priorities and mandate of UNFPA?

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<p><u>EQ10 Assumption 1: UNFPA global mandates are being effectively implemented within the UNDAF in all four program areas.</u></p>	<p>1. Mapping of key global UNFPA (e.g. SP 2014-2017 and SP 2018-2021) mandates and priorities within UNDAF strategic documents and annual program activities for each of the four program areas.</p>	<p>1. UNFPA Global Strategy documents (UNFPA SP 2014-2017 and SP 2018-2021) 2. Senior UNFPA CO and UNCT management, 3. UNDAF strategy and reporting documents 4. UNDAF Midterm review, 5. UNDAF Annual Reports. 6. UNFPA CP COARS</p>	<p>1. Document review, 2. Key stakeholder interviews with UNFPA CO staff as well as UNCT (UNRC and theme group members).</p> <p>(NB: The above for each of the four program areas).</p>

EQ10 Assumption 1:

UNFPA strategic priorities have been well represented in UNDAF. UNFPA has regularly participated in drafting of regular biannual joint work plans. In the area of health, under the Social Inclusion outcome, UNFPA has committed to the following in the periods 2015-2016 and 2017-2018: development and implementation of evidence-based SRH guidelines, development of FP curriculum, establishing of BtN methodology for maternal death surveillance at pilot sites, and integrating elements of Minimum Initial Service Package for Reproductive Health in crisis into emergency preparedness plans (under Outcome 3 of Pillar 1 on Rule of Law and Human Security). This is in line with priorities defined by UNFPA Strategic Plans under components related to SRHR.

In the areas of health and education, also under Social Inclusion, UNFPA has committed to the following in the periods 2015-2016 and 2017-2018: strengthening capacity and provision of support to relevant key stakeholders in development and implementation of CSE, and providing support to the relevant stakeholders in implementation of BiH Roma Action Plan. This is in line with priorities defined by UNFPA Strategic Plans under components related to SRHR, and Youth and Adolescents.

In the area of gender equality, under the pillars of Human Security, Social Inclusion (UNDAF 2010-2014) and Empowerment of Women (UNDAF 2015-2019/(2020)), UNFPA has ensured alignment with its global Strategic Plans in this area. In the UNDAF 2015-2019(2020), UNFPA, in cooperation with other UN agencies, pledged to contribute to achievement of outcomes 12 and 13 under Pillar 4 Empowerment of Women by 1. establishing coordination body/ies at different levels to monitor and implement the Istanbul Convention and UPR recommendations, including for reproductive health, 2. assessing available services for CRSV and gathering necessary data, through researches on masculinities, service assessments, CRSV stigma and perception, the strength of referral mechanisms (formal and informal ones linked to existing Free Legal Aid and Victim Witness Networks), compendium of actors in CRSV, 3. establishing a number of protocols for referrals within health and multi-sector service

referrals in selected locations, including minimum standards for service provision in health for CRSV survivors in a selected locations, 4. engaging CSOs in psycho-social support to perpetrators of violence, including through provision of capacity building activities, partnership initiatives with governmental organizations and advocacy, 5. Reducing discrimination and stigma against CRSV survivors through innovative solutions and best practices in fighting stigma at societal and service providers' level, 6. Designing and implementing forum theatre plays on child protection issues, such as violence and child marriage, and where and how to seek support in all primary schools in 6 municipalities.

Under UNDAF 2010-2014 Outcome 1 Democratic Governance the specific Outcome 1.1 is planned: Government at all levels is able to base policies on quantitative and qualitative analysis of disaggregated data, policy assessments and reviews, with focused attention on socially excluded groups and migrant populations. This is related to work on evidence-based population policies. The work relating to older persons has been integrated under Social Inclusion outcome. UNDAF 2015-2019(2020) does not single out evidence-based policy making, but work relating to status of older persons is accounted for under Outcome 9 “By 2019, targeted legislation, policies, budget allocations and inclusive social protection systems are strengthened to pro-actively protect the vulnerable.” Under this outcome, in the WP 2015-2016 both the work on policies for older persons (Validate social policy guidelines for ageing with entity responsible ministries, draft strategies for ageing at entities levels and establish centres for healthy ageing) and UNFPA’s work on population data (Analyze secondary census data for ageing and gender aspects, analyze potential additional sources of data on migration and gender aspects of migration, and develop population situation analysis) is reflected under the Social Inclusion pillar. In WP (2017-2018) UNFPA’s commitments are Develop draft strategies on ageing in Republika Srpska, Federation of BiH and Brcko District and promote centres for healthy ageing; and Conduct population situation analysis.

It was noted by all stakeholders that UNFPA has managed to integrate its priorities into UNDAF. However, it was also noted that UNDAF is currently a compilation of priorities of different UN agencies, their headquarters, and their project and programmes. There is indication that this could change in the future and that UNDAF should become a more home-grown document, identifying needs and priorities of the country, and then letting agencies contribute to this framework.

COMPONENT 3: ANALYSIS OF THE CP’s STRATEGIC POSITIONING

UNCT COORDINATION

EQ11 To what extent did UNFPA contribute to ensuring programme complementarity, seeking synergies and avoiding overlaps and duplication of activities among development partners working in countries/territory?

Comment(s) on above question:

- Alignment with UNFPA mandates may have changed over time due to the 2018 -2021 Aligned CP Output and Outcomes framework.

Comment(s) on indicators for above question:

- Congruence of UNDAF and UNCT activities, outputs and outcomes with the 2018 - 2021 UNFPA Aligned CP framework. Qualitative data on UNCT recognition of UNFPA CO contributions to UNDAF.

EQ11.A To what extent did UNFPA contribute to ensuring programme complementarity, seeking synergies and avoiding overlaps and duplication of activities among development partners working in countries/territory?

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ11.A Assumption 1: UNFPA has contributed to ensuring program</u>	1. Congruence of UNDAF and UNCT activities, outputs and outcomes with	1. Senior UNFPA staff management, 2. CPD,	1. Document review,

<u>complementarity, seeking synergies and avoided overlaps and duplication of activities among development partners.</u>	the 2018 - 2021 UNFPA Aligned CP framework. Qualitative data on UNCT recognition of UNFPA CO contributions to UNDAF.	3. UNDAF documents, 4. UNDAF Midterm review, 5. UNCT Annual Reports.	2. Key stakeholder interviews.
<p>EQ11.A Assumption 1: Findings including analysis for all pertinent program areas: 1. Sexual and Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD.</p> <p>There is no evidence of overlap between UNFPA and other UN agencies at the activity level in UNDAF and UNCT reports so far. However, there are at least two traditional areas of potential overlap with other UN agencies, which is with UNWOMEN in the sphere of gender equality, and with UNICEF in the sphere of youth. Stakeholders have confirmed that there has been no overlap at the project activity level, but rather that complementarities and synergies have been established. The evidence for this is joint work with UNICEF on early marriage prevention, work with UNHCR in the field on protection of GBV victims during migrant crisis, utilization of WHO's BtN methodology alongside clear delineation between mandates for communicable and noncommunicable diseases, or distribution of intervention areas among four agencies as part of the Joint Project Seeking Care, Support and Justice for Survivors of Conflict Related Sexual Violence in BiH. Concerning the latter, UNFPA's work on health referrals and destigmatization has been clearly delineated from other interventions as part of the JP, but there are concerns that the JP has not worked with sufficient synchronization, or rather progress toward a common goal has not been achieved at the same pace by all agencies. Whilst it is questionable whether UNFPA can be faulted for this, individual stakeholders said that UNFPA had not made sufficient effort to coordinate with others and propose more synergies.</p> <p>At the same time, it was observed by stakeholders that other UN agencies have started to step into areas where UNFPA was so far almost an exclusive implementer. These areas include youth and ageing, which is why close coordination is necessary in order to ensure complementary actions. UNFPA's role in promotion of SDGs has not been prominent among UN agencies. Namely, as an agency with clear mandate and strategic priorities related to population dynamics, UNFPA should have assumed a bigger role in promotion and localization of SDGs and relevant measurement and monitoring in BiH, at least in the areas pertinent to UNFPA mandate.</p>			
Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ11.A Assumption 2: The UNFPA CP's core mandated activities, outputs and outcomes as implemented within the country/territory's UNDAF are recognized and acknowledged by UNCT.</u>	<ol style="list-style-type: none"> 1. Congruence of UNDAF and UNCT activities, outputs and outcomes with the 2018 - 2021 UNFPA Aligned CP framework. 2. Qualitative data on UNCT recognition of UNFPA CO contributions. 	<ol style="list-style-type: none"> 1. Senior UNFPA staff management, 2. Senior UNCT staff (UNCR and theme group members) UNFPA CP and PoC documents, 3. UNDAF Midterm review, UNCT Annual Reports. UNCT theme group minutes. 	<ol style="list-style-type: none"> 1. Document review, 2. Key stakeholder interviews with UNCT senior staff as well as UNFPA CO staff. <p>(NB: The above for each of the four program areas).</p>
EQ11.A Assumption 2:			

There is evidence that UNFPA participated in the reporting of the UNCT in the period 2015-2017 (see reports), but the method of reporting has changed at the UNCT level. Namely, the latest, 2017 report, does not single out contributions of individual agencies any more, but reports on UNCT achievements as a whole. However, stakeholders have confirmed UNFPA's contribution to implementation of UNDAF, its active role in Results Groups, and initiative for establishment of new groups to address so far missing joint commitment to individual areas and target groups, e.g. youth.

ADDED VALUE

EQ12 What is the main UNFPA added value in the country/territory context as perceived by national stakeholders?

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<p><u>EQ12 Assumption 1: Assumes that UNFPA has added value in one or more areas within the country/territory context.</u></p>	<ol style="list-style-type: none"> 1. Examples of activities that were influential for the results in a program area. 2. The perceptions of key national stakeholders. 	<ol style="list-style-type: none"> 1. Senior stakeholders at GVT Ministries, UNCT, UNFPA CO, and IP agencies 2. UNFPA program reporting documents. 3. Site Visits 	<ol style="list-style-type: none"> 1. Document review 2. Key stakeholder interviews

EQ12 Assumption 1:

UNFPA is recognized by stakeholders as a small but lean agency with a very specific mandate. Several topics have made UNFPA highly recognizable and valued in the UNCT and among national stakeholders. It was noted by a majority stakeholders that UNFPA addresses issues that no one else does - SRHR and PD. According to stakeholders, UNFPA keeps the debate and programmes alive in the areas that other agencies, or the society in general, do not find easy to talk about. These are the issues of sexual health, sexuality education, sexual and other gender-based violence, victims of violence and their stigmatization, but also some other generally neglected target groups, such as older persons and their well being. Also, it was observed that no other UN agency has the mandate or capacity to lead on population matters. Stakeholders also valued UNFPA's practice to adapt its global standards and tools in particular areas, such as SRHR and GBV in emergencies, or family planning and improving maternal health, among others, to local context. In general, stakeholders have confirmed that UNFPA CP is unique and greatly adds value to the country.

Annex 5 Evaluation Questions for Components 1 and 2 for the CPE

Criteria	Evaluation questions drawn from TOR	Q#
COMPONENT 1: ANALYSIS BY FOCUS AREA		
Relevance		
All 4 Focus Areas (FAs)	EQ 1.A. To what extent is the UNFPA programme (i) adapted to the needs of women, adolescents and youth, people at risk of HIV infections, disabled and older persons, (ii) and in line with the priorities set by the international and national policy frameworks, iii. aligned with the UNFPA policies and strategies and the UNDAF (or equivalent document) as well as with interventions of other development partners? Do planned interventions adequately reflect the goals stated in the UNFPA Strategic Plan?	1
	EQ 1.B. To what extent has the UNFPA office been able to respond to changes in the national development context and, in particular, to the aggravated humanitarian situation in the country/territory?	2
Effectiveness		
All 4 FAs	EQ 2.A. To what extent have the intended programme outputs been achieved? To what extent did the outputs contribute to the achievement of these planned outcomes: i. increased utilization of integrated SRH Services by those furthest behind, ii. increased the access of young people to quality SRH services and sexuality education, iii. mainstreaming of provisions to advance gender equality, and iv. developing of evidence-based national population policies; and what was the degree of achievement of these outcomes?	3
All 4 FAs	EQ 2.B. To what extent has UNFPA contributed to an improved emergency preparedness in BiH, The Republic of North Macedonia, the Republic of Serbia, and Kosovo, and in the area of maternal health / sexual and reproductive health including MISP?	4
All 4 FAs	EQ 2. C. To what extent has each office been able to respond to emergency situations in its Area of Responsibility (AoR), if one was declared? What was the quality and timeliness of the responses?	5
Efficiency		
All 4 FAs	EQ 3. To what extent has UNFPA made good use of its human, financial and technical resources, and has used an appropriate combination of tools and approaches to pursue the achievement of the results defined in the UNFPA programme documents?	6
Sustainability		
All 4 FAs	EQ 4.A. Are programme results sustainable in short and long-term perspectives?	7
All 4 FAs	EQ 4.B. To what extent have the partnerships established by UNFPA promoted the national ownership and sustainability of supported interventions, programmes and policies?	8
COMPONENT 2: ANALYSIS OF UN COUNTRY/TERRITORY TEAM COORDINATION AND ADDED VALUE		
UNCT Coordination		
	EQ5.A. To what extent did UNFPA contribute to coordination mechanisms in the UN system at country/territory level?	9
	EQ5.B. To what extent does the UN Development Framework reflect the interests, priorities and mandate of UNFPA?	10
	EQ5.C To what extent did UNFPA contribute to ensuring programme complementarity, seeking synergies and avoiding overlaps and duplication of activities among development partners working in countries/territory?	11

Added Value		
	EQ6.D What is the main UNFPA added value in the area context as perceived by UNCT, government and civil society organizations?	12

Annex 6 Methodological Tools

UNFPA CP Evaluation

Draft Stakeholder Interview Questionnaire

**This questionnaire is intended for a full range of stakeholders:
(Ministry counterparts, Implementing partners, Donors, NGOs, and UN agency staff)**

Draft 0.2

Preliminary Draft – Not for Distribution

24 October 2018

Introduction: Thank you for agreeing to meet with us today. Our names are XXX and YYY. We are evaluation consultants and have been hired to conduct an end-of-project evaluation of the UNFPA CP for 20XX- 20XX. This project began in 20XX and the program has been implemented in collaboration with [name of country/territory] Ministries and a wide range of other stakeholders.

Goals and objectives of the Survey: After more than XXX years since the beginning of the project, now that many of the components have been implemented, this evaluation will

- a) Assess, as systematically and objectively as possible, the following six criteria: relevance, effectiveness, efficiency, sustainability, United Nations Country/territory Team Coordination, and added value.
- b) Assess the achievements of the project against its X outcomes and Y outputs, and the future needs of [name of country/territory] for Sexual and Reproductive Health and Reproductive Rights (RH&RR), Adolescent/Youth Sexual and Reproductive Health (A/YS&RH), Gender and Gender Based Violence (G&GBV) and Population and Development (PD).
- c) Develop a document that will help key stakeholders, including UNFPA [Name of country/territory], various Ministries and donors, to make reasonable choices regarding the approach towards interventions in the country/territory and the components that should be maintained, modified or added in the upcoming projects.

Ground Rules: This interview is confidential and voluntary. Your name will not be linked to any of the findings. If you are willing to be quoted, this is appreciated. But no data will be associated with your name unless cleared in advance by you. You can end the interview at any time and have no obligation to answer any questions asked.

1. **Date and Location of Interview:** __Day__Mo__Year **Location of Interview:**_____
2. **Name:**
3. **Contact information for clearance:**
4. **Position and Organization:**
5. **Position with respect to policy:** Does the respondent work at a level where he/she has an understanding of national donor policy issues? **Circle one:** Yes No.
6. **Number of years has worked in this position:** _____Years
7. **Confirmation that respondent knows what the UNFPA CP is and what is has done in at least one of the four Outcomes shown below. Validate this by asking them to briefly describe the outcome they are most familiar with and any examples of specific activities UNFPA is supporting in this area.** **Circle one:** i) Little ii) Some iii) Well informed
8. **Which of the following four outcomes/outputs are you most familiar with?**
Circle the one most familiar with.

Outcome 1. Reproductive Health and Reproductive Rights: Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access.

Outcome 2. Adolescent/Youth Sexual and Reproductive Health: Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health.

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

Outcome 4. Population and Development: Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality.

Evaluation Component I: ANALYSIS BY FOCUS AREAS

Introduction “You have said that you are most familiar with Outcome [mention the outcome or outcomes they are most familiar with]. We would like to ask some questions about this particular outcome/ these particular outcomes and the UNFPA Country Program (CP) as a whole.

If you feel the question is too general or is at a policy level you are not comfortable with, this is not a problem. We will skip to the next question.”

9. Relevance

NB: The following questions apply to all 4 Focus areas.

Question 9a: (EQ 1.A). In your opinion, to what extent is the UNFPA programme:

- (i) adapted to the needs of women, adolescents and youth, people at risk of HIV infections, disabled and elderly persons?**

- (ii) in line with the priorities set by the international and national policy frameworks?**

- (iii) aligned with the UNFPA policies and strategies and the UNDAF (or equivalent document) as well as with interventions of other development partners?**

Question 9b: (EQ 1.A.iv) In your opinion, do planned interventions [supported by UNFPA] adequately reflect the goals stated in the UNFPA Strategic Plan?

Question 9c: (EQ 1B): In your opinion, to what extent has the UNFPA office been able to respond to changes in the national development context and, in particular, to any aggravated humanitarian situations in your country/territory?

10. Effectiveness

NB: These questions (10 a – 10d) apply to all Focus areas.

Question 10a. (EQ2A.1) In your opinion, to what extent have the intended programme outputs been achieved? Before proceeding with this question, confirm that respondent is familiar with at least one output and one outcome.

Please explain:

Question 10b. (EQ2A.2) In your opinion, to what extent have the intended program outputs contributed to the achievement of these planned outcomes? NB: An “output” can refer to any specific UNFPA supported activity the respondent is familiar with that fits within an outcome the respondent is familiar with.

i. increased utilization of integrated SRH Services by those furthest behind,

Please explain:

ii. increased the access of young people to quality SRH services and sexuality education,

Please explain:

iii. mainstreaming of provisions to advance gender equality, and

Please explain:

iv. developing of evidence-based national population policies.

Please explain:

Question 10.C (EQ2A.3) What was the degree of achievement of the outcomes?

Please explain:

Question 10D. (EQ 2.B.) In your opinion, to what extent has...

...UNFPA (Country/territory) contributed to an improved emergency preparedness in your country/territory?

...UNFPA (Country/territory) contributed to improved maternal health / sexual and reproductive health including the Minimum Initial Service Package (MISP) for reproductive health (RH)? MISP is a coordinated set of priority activities designed to prevent excess morbidity and mortality, particularly among women and girls at the onset of humanitarian emergencies.

Please explain:

Question 10.E. (EQ 2. C.)

Part 1. To what extent has the UNFPA [Country/territory] program been able to respond to emergency situations, declared or not declared, during the time period from 2012 to the present?

NB: Skip to next question if no emergency situations occurred during this time period.

Please explain:

Part 2. What was the quality and timeliness of the UNFPA [Country/territory] response to any emergency situations?

Please explain:

11. Efficiency NB: These questions apply to all Focus areas

Question 11a. (EQ3.A)

Part 1.a In your opinion, to what extent has UNFPA made good use of its human resources to pursue the achievement of the results defined in the UNFPA programme documents?

Please explain:

Part 1.b In your opinion, to what extent has UNFPA made good use of its financial resources to pursue the achievement of the results defined in the UNFPA programme documents?

Please explain:

Part 1.c In your opinion, to what extent has UNFPA made good use of its technical resources to pursue the achievement of the results defined in the UNFPA programme documents?

Please explain:

Part 2. In your opinion, to what extent has UNFPA used an appropriate combination of tools and approaches to pursue the achievement of the results defined in the UNFPA programme documents?

Please explain:

12. Sustainability

NB: These questions apply to all focus areas

Question 12a.1 (EQ 4.A.1) In your opinion, are programme results sustainable in a short-term perspective (≤ 3 years)?

Please explain:

Question 12a.2 (EQ 4.A.2) In your opinion, are programme results sustainable in a long-term perspective (> 3 years)?

Please explain:

Question 12b. (EQ 4.B).

Part 1: Are you familiar with any partnerships established by UNFPA? Yes or no.

If yes, please describe them.

Part 2: In your opinion, to what extent have the above mentioned partnerships established by UNFPA promoted the national ownership and sustainability of supported interventions, programmes and policies?

Component II: ANALYSIS OF UN Country/territory Team coordination and UNFPA added value.

NB: THESE QUESTIONS SHOULD ONLY BE POSED TO SENIOR AND MID-LEVEL LEVEL STAFF WHO ARE FAMILIAR WITH UNCT AND NATIONAL LEVEL DONOR DEVELOPMENT POLICY LEVEL MATTERS.

Question 13a (EQ5.A.) In your opinion, to what extent did UNFPA contribute to coordination mechanisms in the UN system at the country/territory level?

Question 13.b (EQ5.B.) In your opinion, to what extent does the UNDAF/ UN Partnership Framework, reflect the interests, priorities and mandate of UNFPA?

Question 13c. (EQ6.A.) In your opinion, to what extent did UNFPA contribute to ensuring programme complementarity, seeking synergies and avoiding overlaps and duplication of activities among development partners working in your country/territory?

14. Added Value

Question 14. (EQ6.D.) In your opinion, what is the main UNFPA added value in your country/territory?

Question 15. In your view, what are the most significant achievements/changes in the country/territory in the last five years in the areas of health, including Reproductive health, Women's empowerment, Adolescent empowerment, and Population dynamics? List all below.

For each of the above achievements or changes in the country/territory, has there been any contribution by UNFPA in achieving them? If so, how?

Question 16. Do you have any final comments you would like to share about UNFPA?

Thank you for your cooperation.

UNFPA CP Evaluation
Draft Stakeholder Interview Questionnaire
Translated to local language

**This questionnaire is intended for a full range of stakeholders:
(Ministry counterparts, Implementing partners, Donors, NGOs, and UN agency staff)**

Draft 0.2

Preliminary Draft – Not for Distribution

24 October 2018

Uvod: Hvala što ste pristali da se sastanete sa nama. Ja sam Nina Karađinović, konsultantica odabrana da provede konačnu evaluaciju UNFPA programa za Bosnu i Hercegovinu od 2013 do 2018 godine. Ovaj program je počeo 2010. godine i program je implementiran u saradnji sa ministarstvima na državnom i entitetskom nivou i mnogim drugim zainteresiranim stranama.

Ciljevi intervjua: Nakon više od 7 godina od početka ovog projekta, sad kad su mnoge od komponenti implementirane, ova evaluacija će

- a) ocijeniti, sistematski i objektivno koliko je to moguće, sljedećih šest kriterija: relevantnost, efektivnost, efikasnost, održivost, koordinaciju Tima Ujedinjenih Nacija u Bosni i Hercegovini, i dodatnu vrijednost UNFPA;
- b) ocijeniti dostignuća projekta prema 4 ishoda i 4 rezultata, i buduće potrebe u Bosni i Hercegovini u oblastima seksualnog i reproduktivnog zdravlja i reproduktivnih prava, seksualnog i reproduktivnog zdravlja adolescenata/mladih, roda i rodno zasnovanog nasilja, i populacije i razvoja;
- c) razviti dokument koji će pomoći ključnim zainteresiranim stranama uključujući UNFPA u Bosni i Hercegovini, razna ministarstva i donatore, da donose racionalne odluke u vezi intervencija u Bosni i Hercegovini i komponenti koje se trebaju održavati, promijeniti ili dodati u narednim projektima.

Temeljna pravila: Ovaj intervju je povjerljiv i učešće je na dobrovoljnoj osnovi. Vaše ime neće biti povezano sa bilo kakvim zaključcima. Ukoliko pristajete da citiramo Vaše izjave, to bismo cijenili, ali nijedan podatak neće biti asociiran sa Vašim imenom ako Vi na to izričito ne pristanete unaprijed. Možete prekinuti ovaj intervju u bilo kojem trenutku i niste obavezni da odgovorite na bilo koje postavljeno pitanje.

9. **Datum i lokacija intervjua:** ___Dan___Mj___God **Lokacija intervjua:** _____

10. **Ime:**

11. **Kontakt informacija za dodatna pitanja:**

12. **Pozicija u organizaciji:**

13. **Pozicija u odnosu na politike:** Da li sagovornik/ca radi na nivou gdje razumije pitanja donatorskih politika u državi? **Zaokružiti:** Da Ne.

14. **Broj godina koliko sagovornik/ca radi na ovoj poziciji:** _____ godina

15. **Potvrda da sagovornik/ca zna šta je UNFPA program** i da zna šta je urađeno prema makar jednom od ishoda navedenih ispod. **Pitati da kratko opišu ishod s kojim su najbolje upoznati i bilo kakve primjere specifičnih aktivnosti koje je UNFPA podržala u vezi ove oblasti da bi ovo potvrdili.** **Zaokružiti:** i) Malo informisan(a) ii) Donekle informisan(a) iii) Dobro informisan(a)

16. **Sa kojim od sljedećih četiri ishoda/rezultata ste najbolje upoznati?**

Zaokružiti ishod s kojim su najbolje upoznati.

Ishod 1. Reproduktivno zdravlje i reproduktivna prava: Povećana dostupnost i upotreba integrisanih usluga seksualnog i reproduktivnog zdravlja (uključujući planiranje porodice, maternalno zdravlje i HIV) koje su rodno osjetljive i ispunjavanju norme ljudskih prava u oblasti kvalitete njege i jednakosti pristupa.

Ishod 2. Seksualno i reproduktivno zdravlje adolescenata/mladih: Veći prioritet dat adolescentima, naročito veoma mladim djevojkama, u politikama institucija i programima razvoja, naročito povećana dostupnost sveobuhvatnog seksualnog obrazovanja i seksualnog i reproduktivnog zdravlja.

Ishod 3. Rod i rodno zasnovano nasilje: Unaprijeđena rodna ravnopravnost, osnaživanje žena i djevojčica, i reproduktivna prava, uključujući i najranjivije i marginalizirane žene, adolescentice i mlade djevojke.

Ishod 4. Populacija i razvoj: Unaprijeđene politike institucija i agende međunarodnog razvoja kroz integraciju analiza populacijske dinamike koje su zasnovane na dokazima i njihovim poveznica sa održivim razvojem, seksualnim i reproduktivnim zdravljem i reproduktivnim pravima, HIV-om i rodnom ravnopravnošću.

I komponenta evaluacije: Analiza prema fokusnim oblastima

Uvod: “Rekli ste da ste najviše upoznati sa ishodom [spomenuti ishod ili ishode s kojima su najviše upoznati]. Želimo Vam postaviti nekoliko pitanja u vezi ovog specifičnog ishoda/ovih specifičnih ishoda i generalno u vezi UNFPA programa u BiH.

Ako smatrate da je pitanje previše generalno ili je na nivou politika sa kojima niste upoznati, to nije problem. Jednostavno ćemo preći na sljedeće pitanje.“

9. Relevantnost

NB: Sljedeća pitanja se tiču svih 4 fokusne oblasti.

Pitanje 9a: (EQ 1.A). Prema Vašem mišljenju, uolikoj mjeri je UNFPA program:

- (iv) prilagođen potrebama žena, adolescenata i mladih, ljudi pod rizikom od HIV infekcije, osoba sa invaliditetom, i osoba starije životne dobi?

- (v) usklađen sa prioritetima postavljenih međunarodnim i domaćim okvirnim politikama?

- (vi) Usklađen sa politikama i strategijama UNFPA i UNDAF-om kao i sa intervencijama drugih razvojnih partnera?

Pitanje 9b: (EQ 1.A.iv) Prema Vašem mišljenju, da li planirane intervencije [koje podržava UNFPA] adekvatno reflektuju ciljeve zadate u Strateškom planu UNFPA?

Pitanje 9c: (EQ 1B): Prema Vašem mišljenju, do koje mjere je kancelarija bila u mogućnosti da odgovori na promjene u razvojnom kontekstu unutar države, naročito na bilo kakve pogoršane humanitarne situacije u Vašoj državi?

10. Efektivnost

NB: Ova pitanja (10 a – 10d) se tiču svih fokusnim oblastima.

Pitanje 10a. (EQ2A.1) Prema Vašem mišljenju, do koje mjere su ostvareni planirani ishodi programa? Prije nego postavite ovo pitanje, potvrdite da je sagovornik/ca upoznat sa makar jednim rezultatom i jednim ishodom.

Molimo objasnite:

Pitanje 10b. (EQ2A.2) Prema Vašem mišljenju, do koje mjere su planirani rezultati programa doprinijeli tome da se postignu ovi planirani ishodi? NB: „Rezultat“ može biti bilo koja aktivnost podržana od strane UNFPA sa kojom je sagovornik/ca upoznat(a) a koja pripada ishodu s kojim je sagovornik/ca upoznat.

v. povećana upotreba integrisanih usluga seksualnog i reproduktivnog zdravlja od strane marginaliziranih grupa,

Molimo objasnite:

vi. povećana dostupnost mladim ljudima kvalitetnih usluga seksualnog i reproduktivnog zdravlja i seksualnog obrazovanja,

Molimo objasnite:

vii. integriranje principa rodne ravnopravnosti, i

Molimo objasnite:

viii. razvoj domaćih populacijskih politika zasnovanih na dokazima.

Molimo objasnite:

Pitanje 10.C (EQ2A.3) Do koje mjere su ostvareni ishodi?

Molimo objasnite:

Pitanje 10D. (EQ 2.B.) Po Vašem mišljenju, do koje mjere je...

...UNFPA BiH doprinio poboljšanju pripravnosti za vanredne situacije u Vašoj državi?

...UNFPA BiH doprinio boljem maternalnom zdravlju/seksualnom i reproduktivnom zdravlju uključujući i MISP (Minimalni incijalni paket usluga) za reproduktivno zdravlje? MISP je koordinirani set prioriternih aktivnosti kreiran da spriječi preveliko obolijevanje i smrtnost, naročito među ženama i djevojčicama pri situacijama vanredne humanitarne potrebe.

Molimo objasnite:

Pitanje 10.E. (EQ 2. C.)

Dio 1. Do koje mjere je UNFPA BiH program bio u mogućnosti da odgovori na vanredna stanja, proglašena ili ne, tokom vremenskog perioda od 2012. godine do sad?

NB: Ako nije bilo vanrednih stanja u ovom vremenskom periodu, preći na sljedeće pitanje.

Molimo objasnite:

Dio 2. Kakav je bio kvalitet i blagovremenost odgovora UNFPA BiH u situacijama vanrednog stanja?

Molimo objasnite:

11. Efikasnost NB: Ova pitanja se tiču svih fokusnih oblasti

Pitanje 11a. (EQ3.A)

Dio 1.a Po Vašem mišljenju, do koje mjere je UNFPA optimalno koristio svoje kadrovske resurse u postizanju rezultata definiranih programskim dokumentom UNFPA?

Molimo objasnite:

Dio 1.b Po Vašem mišljenju, do koje mjere je UNFPA optimalno koristio svoje finansijske resurse u postizanju rezultata definiranih programskim dokumentom UNFPA?

Molimo objasnite:

Dio 1.c Po Vašem mišljenju, do koje mjere je UNFPA optimalno koristio svoje tehničke resurse u postizanju rezultata definiranih programskim dokumentom UNFPA?

Molimo objasnite:

Dio 2. Po Vašem mišljenju, do koje mjere je UNFPA koristio odgovarajuću kombinaciju instrumenata i pristupa u postizanju rezultata definiranih u programskom dokumentu UNFPA?

Molimo objasnite:

12. Održivost

NB: Ova pitanja se tiču svih fokusnih oblasti

Pitanje 12a.1 (EQ 4.A.1) Po Vašem mišljenju, da li su rezultati programa održivi u kratkoročnoj perspektivi (<=3 godine)?

Molimo objasnite:

Pitanje 12a.2 (EQ 4.A.2) Po Vašem mišljenju, da li su rezultati programa održivi u dugoročnoj perspektivi (> 3 godine)?

Molimo objasnite:

Pitanje 12b. (EQ 4.B).

Dio 1: Da li ste upoznati sa nekim partnerstvima koje je formirao UNFPA? Da ili ne.

Ako da, molimo opišite ih.

Dio 2: Po Vašem mišljenju, do koje mjere su gore spomenuta partnerstva koja je formirao UNFPA unaprijedila domaća odgovornost za podržane intervencije, programe i politike, i njihovu održivost?

II komponenta: Analiza koordinacije Tima Ujedinjenih nacija i dodane vrijednosti UNFPA.

NB: OVA PITANJA TREBALA BI BITI POSTAVLJENA SAMO VISOKIM I VIŠIM SLUŽBENICIMA KOJI SU UPOZNATI SA TIMOM UJEDINJENIH NACIJA I PITANJIMA DONATORSKIH POLITIKA ZA RAZVOJ U DRŽAVI.

Pitanje 13a (EQ5.A.) Po Vašem mišljenju, do koje mjere je UNFPA doprinio koordinacijskim mehanizmima UN sistema u BiH?

Pitanje 13.b (EQ5.B.) Po Vašem mišljenju, do koje mjere UNDAF odražava interese, prioritete i mandate UNFPA?

Pitanje 13c. (EQ6.A.) Po Vašem mišljenju, do koje mjere je UNFPA doprinio tome da programi budu komplementarni, tražeći sinergije i izbjegavajući preklapanja i duplikaciju aktivnosti između razvojnih partnera u Vašoj državi?

14. Dodana vrijednost

Pitanje 14. (EQ6.D.) Po Vašem mišljenju, koja je glavna dodana vrijednost UNFPA u Vašoj državi?

Pitanje 15. S Vašeg stanovišta, koja su najznačajnija dostignuća/promjene u državi u posljednjih pet godina u oblastima zdravlja, uključujući i reproduktivno zdravlje, osnaživanju žena, osnaživanju adolescenata i populacionoj dinamici? Navedite ih sve ispod.

Za svako gore navedeno dostignuće ili promjenu u državi, da li je UNFPA doprinio u njihovom ostvarivanju? Ako da, na koji način?

Pitanje 16. Imate li bilo kakvih finalnih komentara koje biste željeli podijeliti sa UNFPA?

Zahvaljujemo Vam na saradnji.

Training Follow-up Questionnaire Draft 0.2 – 1 November 2018 Preliminary – Do not distribute

Introduction: Explain purpose of interview as part of evaluation of the UNFPA Country/territory Program. Explain that the interview is voluntary and confidential; no data will be linked to them. **Do not write name.**

<p>1. Unique Questionnaire ID Number: ___/___</p> <p>2. Date: dd/mm/yr</p> <p>3. Name of interviewer:</p>	<p>4. Location of Interview (Name Office and Town)</p>
<p>5. Normal place of residence:</p> <p>6. Normal place of employment:</p>	<p>7. Sex: Male/Female</p> <p>8. Age:</p>
<p>9. Category of trainee: (Indicate background, for example, Family Dr, GP, Nurse, Peer Educator, Police, Ministry official, Other):</p> <p>10. If nurse or doctor: Level of Medical training completed _____</p> <p>11. For Peer Educator or other: Educational level completed: Less than Secondary, Secondary, college, post graduate.</p>	
<p>12. What type of training did you receive? (NB: <u>Probe to be sure it was funded through the UNFPA Program</u>) Circle one from the following list of trainings (Please select the most recent training you received): (NB: A list of trainings will be included here for the respondent to check.)</p> <p>a.) Training on X b.) Training on Y c.) Training on Z d.) Other trainings.</p>	
<p>13. Was this training useful to you? Yes No (Please explain)</p> <p>14.a. Did you gain new information? Yes No (please explain)</p> <p>14.b. Did you gain new skills? Yes No (please explain)</p>	
<p>15. What did you find the least useful from this training? _____</p> <p>16. Were you able to apply the knowledge and skills from your training on a regular basis? Yes or No. Explain your answer. _____</p>	
<p>17. Was there any post-training support by the UNFPA program? If Yes, Explain. _____</p> <p>If no, do you think that is important? _____</p> <p>If Don't know, code 8 for not applicable.</p> <p>18. Did you find the training improved the quality of your program activities? Yes/No. Explain _____</p> <p>19. Would you want to have additional training? Yes or No.</p> <p>20. If yes, what kind of training would be most beneficial for you now?</p> <p>If no, why not?</p>	

Training Follow-up Questionnaire (Local language) Draft 0.2 – 1 November 2018 Preliminary – Do not distribute

Uvod: Objasniti svrhu intervjuja u sklopu evaluacije UNFPA BiH programa. Objasniti da je intervju na dobrovoljnoj bazi i povjerljiv; podaci se neće asociirati sa sagovornicima/ama. **Ne pisati ime.**

1. Jedinstveni ID broj ispitanika: t / _____	4. Lokacija intervjuja: (Naziv kancelarije i grad) _____
2. Datum: dd/mm/gg _____	
3. Ime ispitivača: _____	
5. Uobičajeno mjesto prebivališta: _____	7. Spol: Muški / Ženski
6. Uobičajeno mjesto zaposlenja: _____	8. Starost: _____

9. Kategorija učesnika treninga: (Na primjer, doktor porodične medicine, doktor opće prakse, medicinska sestra/tehničar, vršnjački edukator, policija, činovnik ministarstva, drugo):

10. Ako je medicinska sestra/tehničar ili doktor: Dostignuti nivo medicinskog obrazovanja

11. Za vršnjačke edukatore i druge: Dostignuti nivo obrazovanja:
Manje od srednje škole Srednja škola Fakultet Post-diplomski studij.

12. U kojoj vrsti treninga/obuke ste učestvovali? (NB: Provjeriti da li je trening finansiran od strane UNFPA programa)

Zaokružiti jedan trening na sljedećoj listi:
(Molimo označite posljednji trening u kojem ste učestvovali):
(NB: Lista treninga će biti uključena ovdje da ispitanik provjeri.)

- a.) Trening iz oblasti X
- b.) Trening iz oblasti Y
- c.) Trening iz oblasti Z
- d.) Drugi treninzi.

13. Da li Vam je trening bio koristan? Da Ne

Molimo objasnite: _____

14.a. Da li ste saznali nove informacije? Da Ne

Molimo objasnite: _____

14.b. Da li ste stekli nove vještine? Da Ne

Molimo objasnite: _____

15. Šta smatrate da je bilo najmanje korisno na ovom treningu? _____

16. Da li ste bili u mogućnosti da redovno primjenjujete znanje i vještine sa ovog treninga? Da Ne.

Objasnite Vaš odgovor: _____

17. Da li je postojala neka druga podrška nakon treninga od strane UNFPA programa? Ako da, pojasnite:

Ako ne, smatrate li da je to važno?

Ako je odgovor „Ne znam“, kodirati kao 8.

18. Smatrate li da je trening poboljšao kvalitet Vaših programskih aktivnosti? Da Ne

Objasniti: _____

19. Da li biste željeli dodatni trening? Da Ne

20. Ako da, koja vrsta treninga bi Vam najviše koristila? _____

Ako ne, zašto ne? _____

Client/Beneficiary Questionnaire (Draft 0.1 – Do not distribute) 24 October 2018

Informed Consent Statement for Client/Beneficiaries

Hello, my name is (**name of interviewer**). We are here to learn about the quality of the counselling, information and services you have received from [**Name of Institution in location...**]. We are conducting interviews with people like you who have received services from [**Name of Institution in ...**]. If you agree to participate, we would ask you a few questions about your experience with [**Name of Institution**].

Before I ask you any questions we are required to explain some important ground rules for our interview. Any answers you wish to give are completely **CONFIDENTIAL**, meaning that no one other than me and my colleague will be able to see your answers. Your name and address will **NEVER** be associated with the answers you give. You have every right to refuse to participate in this interview. Whether or not you choose to answer questions will not affect the services you receive from [**Name of Institution**] in any way. If you do agree to answer questions for this evaluation, you may still refuse to answer any question or stop answering questions altogether.

Would it be ok for us to record this interview? Yes or No?

NB: If response is no, proceed with simple note taking for interview.

Interviewer Probe: Do you understand what I have just explained to you? Circle one: Yes/ No.

If no, what do you not understand? [Provide explanations as needed]

Do you now understand what I have just explained to you? Interviewer to Circle one: Yes/No

If no, Thank respondent and discontinue interview.

If yes, Do you agree to be interviewed? Interviewer to Circle One: Yes/No

Signature of Interviewer

Date (dd/mm/yyyy)

Witness (co-interviewer or translator)

Questions for all client/beneficiaries

Q1. Name of Interviewer :

Q2. Date (dd/mm/yyyy):

Q3. Unique Interview Number: ____ ____ ____

Q4. Sex: Male/Female

Q5.a. Age: ____ (to be categorized later)

Q5b. Ethnicity (Albanian, Bosnian, Macedonian, Turkish, Roma, Serb, Other or Not applicable).

Q6. Name of UNFPA supported agency or facility:

Q7. Type of agency: (Maternity Hosp, PHC, other?)

Circle one

Q8. Sector: (Government, Private, NGO, Other)

Circle one

Q9. Educational level of person interviewed:

< secondary, secondary, college, post graduate

Q10. Location of Interview: Town, District Name

Q11. Rural, Urban (within city boundary)

Q12. Current employment if any:

Q13. Region:

Q14. Types of services received: What types of services have you received from this agency? (List types of services, such as counselling, education, referrals, support etc.) _____

Q15. Additional services recommended: **Q15.A.** Are there additional services that you feel this agency should provide? **Q15.B.** If yes, what are they? _____

Respondent perception of usefulness of services:

Q16. Of the services you mentioned, which ones are the most useful to you? _____

Q17. Of the services you mentioned, which ones are the least useful to you? _____

Respondent rating of satisfaction with services:

Q18.A. Are you satisfied with all of the services you mentioned? **Circle one:** Satisfied with all/ Not satisfied with all.

Q18.B. If yes, please explain your answer.

Q19.A. Are you are **not** satisfied with any of the services you mentioned? **Circle one:** Dissatisfied with one or more/ Satisfied with all.

Q19B. If you are not satisfied with one or more services, please explain your answer.

Quality of advice or counselling:

Q20A. Were you satisfied with the advice or counselling you received? **Circle one:** satisfied / not satisfied

Q20B. Please explain your answer:

Respect: Q21.A Were the staff understanding and respectful to you? **Circle one:** Yes / No

Q21B. Please explain your answer:

Recommendations: Q22. What would you recommend to improve the quality of services you received from this agency?

End interview and thank participant!

Izjava o informisanom pristanku za klijente/korisnike

Dobar dan, ja sam Nina Karađinović. Ovdje sam da saznam nešto o kvalitetu savjetovanja, informacija i usluga koje dobivate u [Naziv institucije ili lokacija...]. Radimo intervjuje sa ljudima poput Vas koji su prethodno koristili usluge [Naziv institucije]. Ako pristajete na učešće, pitat ću Vas nekoliko pitanja o Vašim iskustvima sa [Naziv institucije].

Prije nego počnem postavljati pitanja, obavezna sam da Vam pojasnim neka važna osnovna pravila za naš intervju. Svi odgovori koje date su **U POTPUNOSTI** povjerljivi, što znači da niko osim mene i moje kolegice neće moći vidjeti Vaše odgovore. Vaše ime ili adresa **NIKAD** neće biti povezani sa odgovorima koje date. Imate svako pravo da odbijete da učestvujete. To što odaberete da učestvujete ili ne neće ni na koji način utjecati na usluge koje dobivate od [Naziv institucije]. Ako i pristanete da odgovarate na pitanja za ovu evaluaciju, svejedno možete odbiti da odgovorite na bilo koje pojedinačno pitanje ili prestati da uopće odgovarate na pitanja.

Da li je uredu da se ovaj intervju snima? **Da ili Ne?**

NB: Ako je odgovor ne, nastaviti sa jednostavnim pisanjim bilješki za intervju.

Ispitivač: Razumijete li ovo što sam upravo objasnila? **Zaokružiti:** Da / Ne.

Ako ne, šta ne razumijete? **[Pojasniti što je potrebno.]**

Razumijete li sad ono što sam upravo objasnila? **Ispitivač zaokružuje:** Da / Ne

Ako ne, zahvaliti sagovorniku/ci i prekinuti intervju.

Ako da, Slažete li se da budete intervjuirani? **Ispitivač zaokružuje:** Da / Ne

Potpis ispitivača:

Datum (dd/mm/gggg)

Svjedok (pomoćni ispitivač ili prevodilac)

Pitanja za sve klijente/korisnike

Q1. Ime ispitivača:

Q2. Datum (dd/mm/gggg):

Q3. Jedinstveni broj ispitanika: ____ _

Q4. Rod: Muško / Žensko

Q5.a. Starost: **(kategorizacija naknadno)**

Q5b. Etnička pripadnost:

Q6. Naziv ustanove ili objekta podržanog od strane

UNFPA:

Q7. Tip ustanove: (Porodilište, Dom zdravlja, Drugo?)

Zaokružiti.

Q8. Sektor: (Državni, Privatni, NVO, Ostali)

Zaokružiti.

Q9. Nivo obrazovanja intervjuirane osobe:

Niže od srednje škole, Srednjoškolski,

Dodiplomski, Postdiplomski

Q10. Lokacija intervjua: Grad, Naziv oblasti

Q11. Ruralno, Urbano (unutar granica grada)

Q12. Trenutno zaposlenje, ako je zaposlen(a):

.....

Q13. Regija:

.....

Q14. Tip usluge: Koju vrstu usluge ste dobili od ove ustanove? (Nabrojati vrste usluga, kao npr. savjetovanje, obrazovanje, upućivanje, podršku, itd.)

.....
.....

Q15. Preporučene dodatne usluge:

Q15.A. Postoje li dodatne usluge koje mislite da bi ova ustanova trebala pružati? **Da / Ne**

Q15.B. Ako da, koje?

.....

Mišljenje ispitanika o korisnosti usluga:

Q16. Od usluga koje ste spomenuli, koje su Vama najkorisnije?

.....

Q17. Od usluga koje ste spomenuli, koje su Vama najmanje korisne?

.....

Ocjena ispitanika koliko su zadovoljni uslugama:

Q18.A. Da li ste zadovoljni uslugama koje ste spomenuli? **Zaokružiti:** Zadovoljni svim uslugama / Nisu zadovoljni svim uslugama.

Q18.B. Ako da, molim objasnite Vaš odgovor.

.....

.....

.....

.....

Q19A. Da li ste **nezadovoljni** bilo kojom od usluga koje ste spomenuli? **Zaokružiti:** Nezadovoljni jednom ili više usluga / Zadovoljni svim uslugama.

Q19B. Ako niste zadovoljni jednom ili više usluga, molim objasnite Vaš odgovor.

.....

.....

.....

.....

.....

Kvalitet savjeta i savjetovanja:

Q20A. Da li ste bili zadovoljni savjetima ili savjetovanjem koje ste dobili? **Zaokružiti:** Zadovoljni / Nisu zadovoljni

Q20B. Molim objasnite Vaš odgovor:

.....

.....

.....

.....

.....

Poštovanje:

Q21.A Da li je osoblje pokazalo razumijevanje i poštovanje prema Vama? **Zaokružiti:** Da / Ne

Q21B. Molim objasnite Vaš odgovor:

.....

.....

.....

.....

.....

Preporuke: Q22. Šta biste preporučili kako bi se poboljšao kvalitet usluga koje ste dobili od ove ustanove?

.....

.....

.....

.....

.....

Završiti intervju i zahvaliti ispitanicima!

Focus Group Discussion (FGD) Guide

Draft 0.1

Draft Only – Not for Distribution

24 October 2018

Example format to be used as the basis for designing a FGD:

For use with women participants in UNFPA supported-birth preparedness classes

Unique FGD ID Number	____ _ <i>To be filled by evaluation team</i>
Interviewer/Facilitator Name(s)	
Notes on this form taken by (name)	
Date of FGD	Day: ____ Month: ____ Year: 2018
Location: Name of District/City	
Location: Specific Site/Facility	

FGD Participant Information					
Number	Sex Female* and number of children/parity	Age	Current occupation	Participated in UNFPA funded birth preparedness class? Yes/No	How long have they participated in UNFPA funded birth preparedness class?
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

***Husbands of women will not be asked to participate in order to ensure women are not inhibited.**

Introduction: Hello and Thank you for agreeing to meet with us today. Our names are XXX and YYY. We are evaluation consultants and have been hired to conduct an evaluation of UNFPA/**Country/territory** supported programmes that have been implemented since 201X.

We would like to ask you questions about UNFPA/ **Country/territory** supported programs for maternal and child health in Country/territory.

We would like to discuss these programmes with you, as well as your knowledge, beliefs, attitudes, practices related to maternal and child health.

Participation in this discussion today is voluntary and you may decline to answer any individual question. You may also discontinue participation at any time. The information you provide will be kept strictly confidential and will not be disclosed to others.

One of us will be asking the questions, while the other will take notes based on what you say.

We would also like to record the discussion. Is this acceptable to you?

(If any of the participants object, we will not do any recording).

Before beginning, we would like to recommend some ground rules for our discussion.

1. This conversation should be treated as confidential. Whatever is discussed here should not be shared outside of this group after the discussion has finished.
2. Please respect each other's opinions.
3. There is no right or wrong answer.
4. The information you provide will not be linked to you in any way. Your honest responses to our questions will be highly appreciated.

We hope today's discussion will be balanced. This is an open discussion and everyone is entitled to his or her own opinions so please feel free to express what you think and feel.

You are the experts, and we are here to learn from you and ensure that we keep the discussion to a reasonable time. We hope it will not take more than an hour and a half. We will be serving refreshments afterwards.

If any of you would prefer not to participate you can leave any time. Can we begin? Thank you.

All probes are optional but all questions should be asked.

1) To start with, we would ask you about some of your day to day challenges. Can you share any examples of the special challenges you face today as elderly persons? (5 MINUTES)

2) We understand that you have all been using the services of the Healthy Ageing Centre. Can you tell us about why did you decided to be involved in this program? (5 MINUTES)

3a) Please tell about the Healthy Ageing Centre (2 MINUTES)

3b) What kind of services do you receive in the Healthy Ageing Centre? (10 MINUTES)

4)a Can you tell us about any advantages of the Health Ageing Centre programme?(5 MINUTES)

Probe: How do you benefit from this program?

4b) Probe: (If no mention is made of family planning messages). Have you been told about family planning in your birth preparedness program? What have they told you?

4c) Probe: Would you recommend this programme to others?

5a) Can you tell us about any disadvantages of Health Ageing Centre program? (5 MINUTES)

Probes: Are there any problems with this program, any things you do not like about it?

6) What recommendations do you have to improve the Health Ageing Centre program and programs for elderly persons in general? (10 MINUTES)

Thanks for your participation and assistance

Focus Group Discussion (FGD) Guide

Translated to local language

Draft 0.1

Draft Only – Not for Distribution

24 October 2018

Example format to be used as the basis for designing a FGD:

For use with participants in UNFPA supported Healthy Ageing Centres

Jedinstveni FGD ID broj	____ _ <i>Ispunjava tim za evaluaciju</i>
Ime ispitivača/facilitatora	
Ime zapisničara	
Datum fokus grupe	Dan: ____ Mj.: ____ God.: 2019
Lokacija: (naziv grada/naselja)	
Lokacija (adresa)	

Informacije o učesnicima fokus grupe					
Redni br.	Spol	Starost	Trenutno zaposlenje	Koristi usluge Centra za zdravo starenje kojeg finansira UNFPA? Da/Ne	Koliko dugo koristi usluge Centra za zdravo starenje kojeg finansira UNFPA?
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					

Uvod: Dobar dan i hvala vam što ste pristali da se sastanete sa nama. Ja sam Nina Karađinović, a ovo je moja kolegica Sanela Muharemović. Mi smo konsultantice za evaluaciju koje rade na evaluaciji programa Populacijskog fonda UN-a u Bosni i Hercegovini koji se implementiraju od 2013. godine.

Želimo vam postaviti nekoliko pitanja o programima koje prodržava UNFPA u BiH za osobe starije životne dobi.

Želimo razgovarati sa vama o ovim programima, ali i o vašem znanju, vjerovanjima, stavovima, i praksama vezano za usluge za osobe starije životne dobi.

Učešće u ovoj diskusiji je na dobrovoljnoj bazi i vi možete odbiti da odgovorite na bilo koje pitanje. Također možete prestati da učestvujete u bilo kojem trenutku. Informacije koje pružite bit će tretirane kao povjerljive i neće biti podijeljene sa drugima.

Ja ću postavljati pitanja, a Sanela će praviti bilješke na osnovu onoga što vi kažete.

Također bismo htjeli snimiti ovu diskusiju. Da li vam je ovo prihvatljivo?

(Ako bilo ko od učesnika odbije snimanje, diskusija se ne snima).

Prije nego počnemo, želimo preporučiti neka osnovna pravila za našu diskusiju:

1. Ovaj razgovor se treba tretirati kao povjerljiv. Ništa od onoga što ovdje kažemo ne bi se trebalo dijeliti van ove grupe nakon što završimo diskusiju.
2. Molimo vas da poštujete mišljenja jedni drugih.
3. Ne postoji tačan ili pogrešan odgovor.
4. Informacije koje pružite neće biti direktno povezane sa vama. Cijenimo vaše iskrene odgovore na naša pitanja.

Nadamo se da će današnja diskusija biti uravnotežena. Ovo je otvorena diskusija i svi imaju pravo na vlastito mišljenje, tako da molim vas budite slobodni da iskažete ono što mislite i osjećate.

Ovdje ste vi eksperti, a mi smo tu da naučimo nešto od vas i da osiguramo razumno trajanje diskusije. Nadamo se da neće trajati duže od sat i po.

Ako bilo ko do vas ne želi da učestvuje, možete odustati u bilo kojem trenutku. Možemo li početi? Hvala vam.

Potpitanja su opcionalna, ali sva pitanja bi trebala biti postavljena.

1) Za početak, želim vas pitati o vašim dnevnim izazovima. Možete li podijeliti par primjera specifičnih izazova sa kojima se susrećete kao osobe starije životne dobi? (5 MINUTA)

2) Kako razumijemo, vi svi koristite usluge Centra za zdravo starenje. Možete li nam reći zašto ste odlučili da budete uključeni u taj program? (5 MINUTA)

3a) Molimo recite nam nešto više o Centru za zdravo starenje. (2 MINUTE)

3b) Koje vrste usluga dobivate u Centru za zdravo starenje? (10 MINUTA)

	<p>4a) Možete li nam reći postoje li neke prednosti programa Centra za zdravo starenje? (5 MINUTA) Potpitanje: Koje koristi imate od ovog programa?</p>
	<p>4b) 4c) Potpitanje: Da li biste preporučili ovaj program drugima?</p>
	<p>5a) Možete li nam reći postoje li neke manjkavosti programa Centra za zdravo starenje? (5 MINUTA) Potpitanje: Ima li nekih problema sa ovim programom, nešto što vam se ne sviđa?</p>

6) Šta biste preporučili kako bi se poboljšao program Centar za zdravo starenje i programi za starije osobe uopće? (10 MINUTA)

Hvala vam na učešću i pomoći.

Focus Group Discussion (FGD) Guide

Draft 0.1

Draft Only – Not for Distribution

3 April 2019

Example format to be used as the basis for designing a FGD:

For use with youth respondents as part of UNFPA CPE

Unique FGD ID Number	____ _ <i>To be filled by evaluation team</i>
Interviewer/Facilitator Name(s)	
Notes on this form taken by (name)	
Date of FGD	Day: ____ Month: ____ Year: 2018
Location: Name of District/City	
Location: Specific Site/Facility	

FGD Participant Information					
Number	Sex	Age	Current occupation		
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Introduction: Hello and Thank you for agreeing to meet with us today. My name is Nina Karadjinovic and I am one of the evaluation consultants that have been hired to conduct an evaluation of the UNFPA BiH supported programs that have been implemented since 2013.

We would like to ask you questions related to focus areas in which UNFPA BiH has supported programs - sexual and reproductive health and rights, youth, gender equality, and population development..

We would like to discuss these issues with you, as well as your knowledge, beliefs, attitudes, practices related to these focus areas.

Participation in this discussion today is voluntary and you may decline to answer any individual question. You may also discontinue participation at any time. The information you provide will be kept strictly confidential and will not be disclosed to others.

I will be asking the questions, and taking notes based on what you say.

(If any of the participants object, we will not do any recording).

Before beginning, we would like to recommend some ground rules for our discussion.

1. This conversation should be treated as confidential. Whatever is discussed here should not be shared outside of this group after the discussion has finished.
2. Please respect each other's opinions.
3. There is no right or wrong answer.
4. The information you provide will not be linked to you in any way. Your honest responses to our questions will be highly appreciated.

We hope today's discussion will be balanced. This is an open discussion and everyone is entitled to his or her own opinions so please feel free to express what you think and feel.

You are the experts, and we are here to learn from you and ensure that we keep the discussion to a reasonable time. I hope it will not take more than 45 minutes. I will be serving refreshments afterwards.

If any of you would prefer not to participate you can leave any time. Can we begin? Thank you.

All questions should be asked.

1) To start with, we would ask you about some of your day to day challenges. Can you share any examples of the special challenges you face today as young students? (5 MINUTES)

2) We understand that you have been studying at university. Can you tell us to what extent you have been discussing issues related to sexual and reproductive health and rights, youth, gender equality, and population development? (5 MINUTES)

3a) Please tell us which issues do you consider to be the most important regarding youth health and sexual and reproductive health and rights (5 MINUTES)

3b) Please tell us which issues do you consider to be the most important regarding gender equality (5 MINUTES)

All questions should be asked.

3c) Please tell us which issues do you consider to be the most important regarding youth and population development policies (5 MINUTES)

4)a In your opinion, which are the ways to improve youth health and youth education about health? (5 MINUTES)

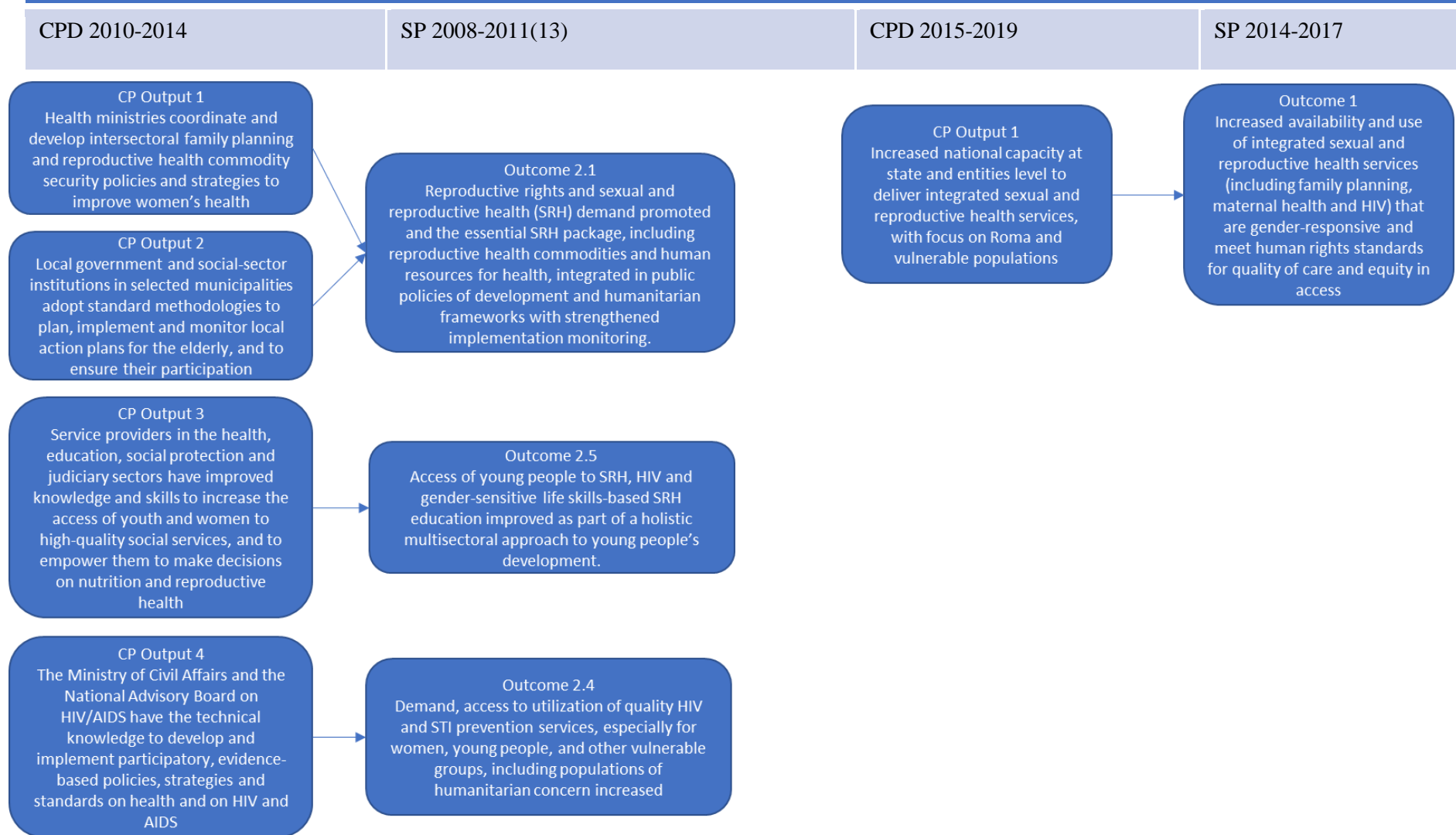
4)b In your opinion, which are the ways to improve gender equality in the country/territory? (5 MINUTES)

4)c In your opinion, which are the ways to improve the demographic situation in the country/territory? (5 MINUTES)

Thanks for your participation and assistance

Annex 7 Logic Model

Reproductive health and rights/Sexual and reproductive health



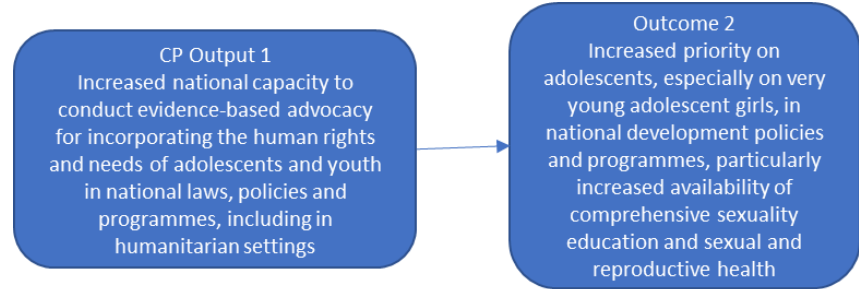
Adolescents and youth

CPD 2010-2014

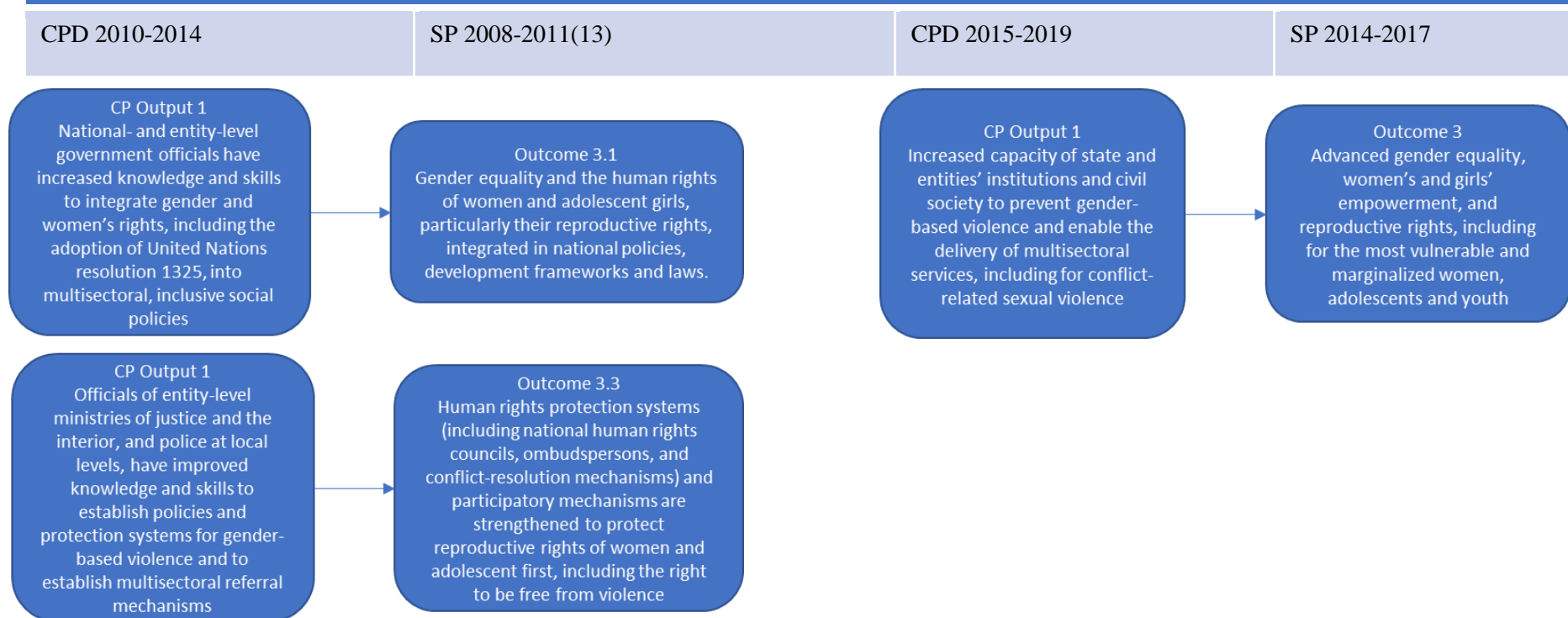
SP 2008-2011(13)

CPD 2015-2019

SP 2014-2017



Gender equality/Gender equality and women's empowerment



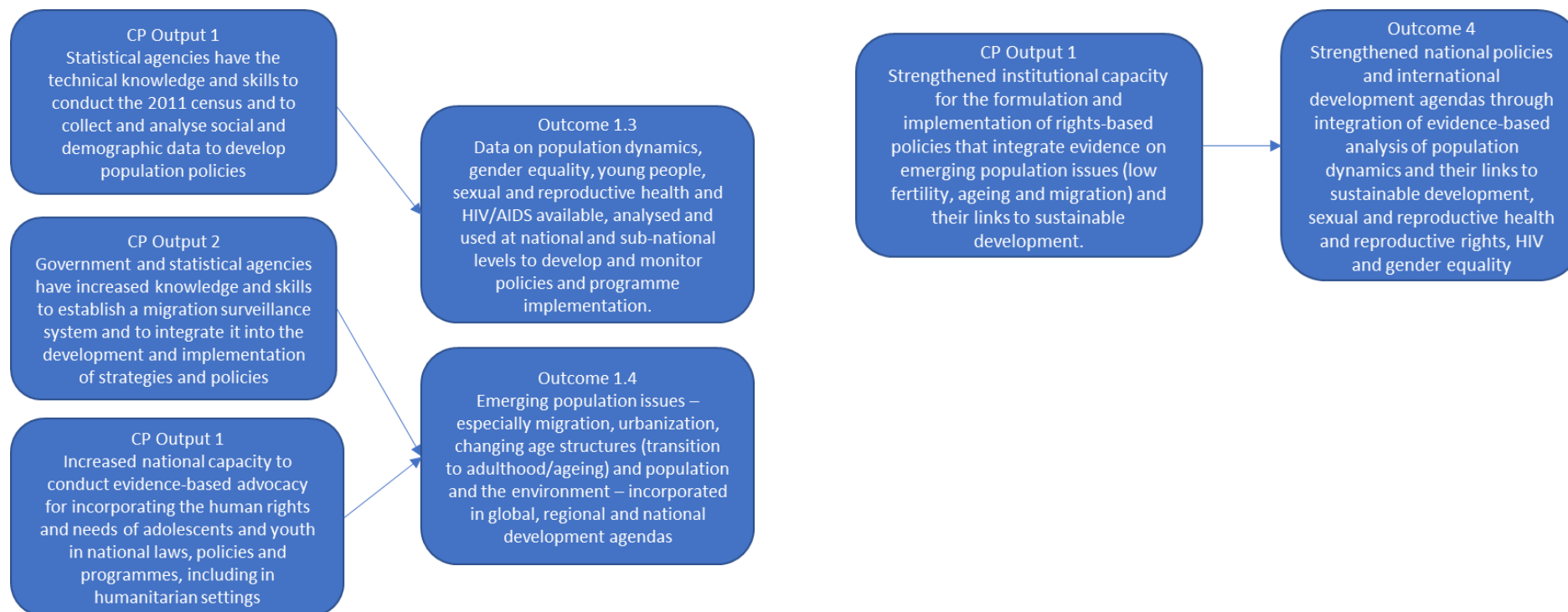
Population and development/Population dynamics

CPD 2010-2014

SP 2008-2011(13)

CPD 2015-2019

SP 2014-2017



Annex 8 Strategic Overview

UNFPA Strategic Plan 2014-2017		UNFPA Strategic Plan 2018-2021	
Achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the ICPD agenda, to improve the lives of adolescents and youth, and women, enabled by population dynamics, human rights and gender equality		Achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the ICPD agenda, to improve the lives of adolescents and youth, and women, enabled by population dynamics, human rights and gender equality	
Outcomes	Outputs	Outcomes	Outputs
1. Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access	Increased national capacity to deliver integrated sexual and reproductive health services	1. Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence	Enhanced capacities to develop and implement policies, including financial protection mechanisms, that prioritize access to information and services for sexual and reproductive health and reproductive rights for those furthest behind, including in humanitarian settings
	Increased national capacity to strengthen enabling environments, increase demand for and supply of modern contraceptives and improve quality of family planning services that are free of coercion, discrimination and violence		Strengthened capacities to provide high-quality, integrated information and services for family planning, comprehensive maternal health, sexually transmitted infections and HIV, as well as information and services that are responsive to emergencies and fragile contexts
	Increased national capacity to deliver comprehensive maternal health services		Strengthened capacities of the health workforce, especially those of midwives, in health management and clinical skills for high-quality and integrated sexual and reproductive health services, including in humanitarian settings
	Increased national capacity to deliver HIV programmes that are free of stigma and discrimination, consistent with UNAIDS unified budget results and accountability framework (UBRAF) commitments		Strengthened capacities to effectively forecast, procure, distribute and track the delivery of sexual and reproductive health commodities, ensuring resilient supply chains
	Increased national capacity to provide sexual and reproductive health services in humanitarian settings		Improved domestic accountability mechanisms for sexual and reproductive health and reproductive rights through the involvement of communities and health-system stakeholders at all levels
2. Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health	Increased national capacity to conduct evidence-based advocacy for incorporating adolescents and youth and their human rights/needs in national laws, policies, programmes, including in humanitarian settings	2. Every adolescent and youth, in particular adolescent girls, is empowered to have access to sexual and reproductive health and reproductive rights, in all contexts	Young people, in particular adolescent girls, have the skills and capabilities to make informed choices about their sexual and reproductive health and rights, and well-being
	Increased national capacity to design and implement community and school based comprehensive sexuality education (CSE) programmes that promote human rights and gender equality		Policies and programmes in relevant sectors tackle the determinants of adolescent and youth sexual and reproductive health, development and well-being

	Increased capacity of partners to design and implement comprehensive programmes to reach marginalized adolescent girls including those at risk of child marriage		Young people have opportunities to exercise leadership and participate in sustainable development, humanitarian action and in sustaining peace
3. Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth	Strengthened international and national protection systems for advancing reproductive rights, promoting gender equality and non-discrimination and addressing gender-based violence	3. Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings	Strengthened policy, legal and accountability frameworks to advance gender equality and empower women and girls to exercise their reproductive rights and to be protected from violence and harmful practices
	Increased capacity to prevent gender-based violence and harmful practices and enable the delivery of multisectoral services, including in humanitarian settings		Strengthened civil society and community mobilization to eliminate discriminatory gender and sociocultural norms affecting women and girls
	Strengthened engagement of civil society organizations to promote reproductive rights and women's empowerment, and address discrimination, including of marginalized and vulnerable groups, people living with HIV and key populations		Increased multisectoral capacity to prevent and address gender-based violence using a continuum approach in all contexts, with a focus on advocacy, data, health and health systems, psychosocial support and coordination
4. Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics, and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality	Strengthened national capacity for production and dissemination of quality disaggregated data on population and development issues that allows for mapping of demographic disparities and socio-economic inequalities, and for programming in humanitarian settings		Strengthened response to eliminate harmful practices, including child, early and forced marriage, female genital mutilation and son preference
	Increased availability of evidence through cutting-edge in-depth analysis on population dynamics, sexual and reproductive health, HIV and their linkages to poverty eradication and sustainable development	4. Everyone, everywhere is counted, and accounted for, in the pursuit of sustainable development	Improved national population data systems to map and address inequalities; to advance the achievement of the Sustainable Development Goals and the commitments of the Programme of Action of ICPD; and to strengthen interventions in humanitarian crises
	Strengthened capacity for the formulation and implementation of rights-based policies (global, regional and country/territory) that integrated evidence on population dynamics, sexual and reproductive health, HIV, and their links to sustainable development		Mainstreamed demographic intelligence to improve the responsiveness, targeting and impact of development policies, programmes and advocacy
	Strengthened national capacity for using data and evidence to monitor and evaluate national policies and programmes in the areas of population dynamics, sexual and reproductive health and reproductive rights, HIV, adolescents and youth and gender equality, including in humanitarian settings		

Annex 9 Overview of UNDAF focus areas/outcome to which UNFPA CP has contributed

UNDAF 2010-2014	UNDAF 2015-2019 (2020)
Focus areas/Outcomes	
<p>DEMOCRATIC GOVERNANCE By the end of 2014, Government with participation of civil society implements practices for more transparent and accountable governance and meets the requirements of the EU Accession process.</p> <p>Outcome 1.1. Government at all levels is able to base policies on quantitative and qualitative analysis of disaggregated data, policy assessments and reviews, with focused attention on socially excluded groups and migrant populations</p>	
<p>SOCIAL INCLUSION By 2014, Government develops and implements policies and practices to ensure inclusive and quality health, education, housing and social protection, and employment services.</p> <p>Outcome 2.1. Government coordinates, monitors, reports on and revises employment, education, housing, health, social protection and cultural policies to be more evidence-based, rights-based and socially inclusive.</p> <p>Outcome 2.2 Municipal authorities, citizens, civil society and the private sector increasingly able to contribute effectively to planning and implementation of inclusive social policies at local level</p> <p>Outcome 2.3 Basic health and education, social protection and employment service providers are better able to ensure access to quality services for socially excluded and vulnerable groups, including marginalized rural poor.</p>	<p>SOCIAL INCLUSION: EDUCATION, SOCIAL PROTECTION, CHILD PROTECTION AND HEALTH</p> <p>Outcome 7. By 2019, all children and young people, including children with disabilities (CwD) and Roma children, benefit from education tailored to their needs and abilities</p> <p>Outcome 9. By 2019, targeted legislation, policies, budget allocations and inclusive social protection systems are strengthened to proactively protect the vulnerable) * The vulnerable include: IDPs, returnees, children, adults and children with disabilities, Roma, women, migrants, asylum seekers, and the elderly.</p> <p>Outcome 11. By 2019, provision of targeted health and public health planning documents and services, including management of major health risks, and promotion of targeted health seeking behaviours, is enhanced. *Key health seeking behaviors involve: immunization, infant feeding, responsive parenting, safe sexual practices, family planning, healthy diet and lifestyle choices.</p>
<p>HUMAN SECURITY By 2014, Government adopts policy, regulatory and institutional frameworks to address human security challenges, including threats posed by communicable diseases and disasters, landmines and small arms and light weapons, armed violence, and also addresses the issues of migration and women, peace and security.</p> <p>Outcome 4.1. Government at central and local level develops regulatory and institutional frameworks to mitigate risk and respond to disasters and outbreaks of communicable diseases, including HIV/AIDS, tuberculosis and pandemic influenza</p> <p>Outcome 4.4. Security and law enforcement sector agencies integrate gender equality issues and mainstreams gender into its policies and protocols and take action to protect women against violence</p>	<p>RULE OF LAW AND HUMAN SECURITY</p> <p>Outcome 1. By 2019, access to justice, non-discrimination and equality under the rule of law is improved</p> <p>Outcome 2. By 2019, BiH consolidates and strengthens mechanisms for peaceful resolution of conflicts, reconciliation, respect for diversity and community security</p> <p>Outcome 3.</p>

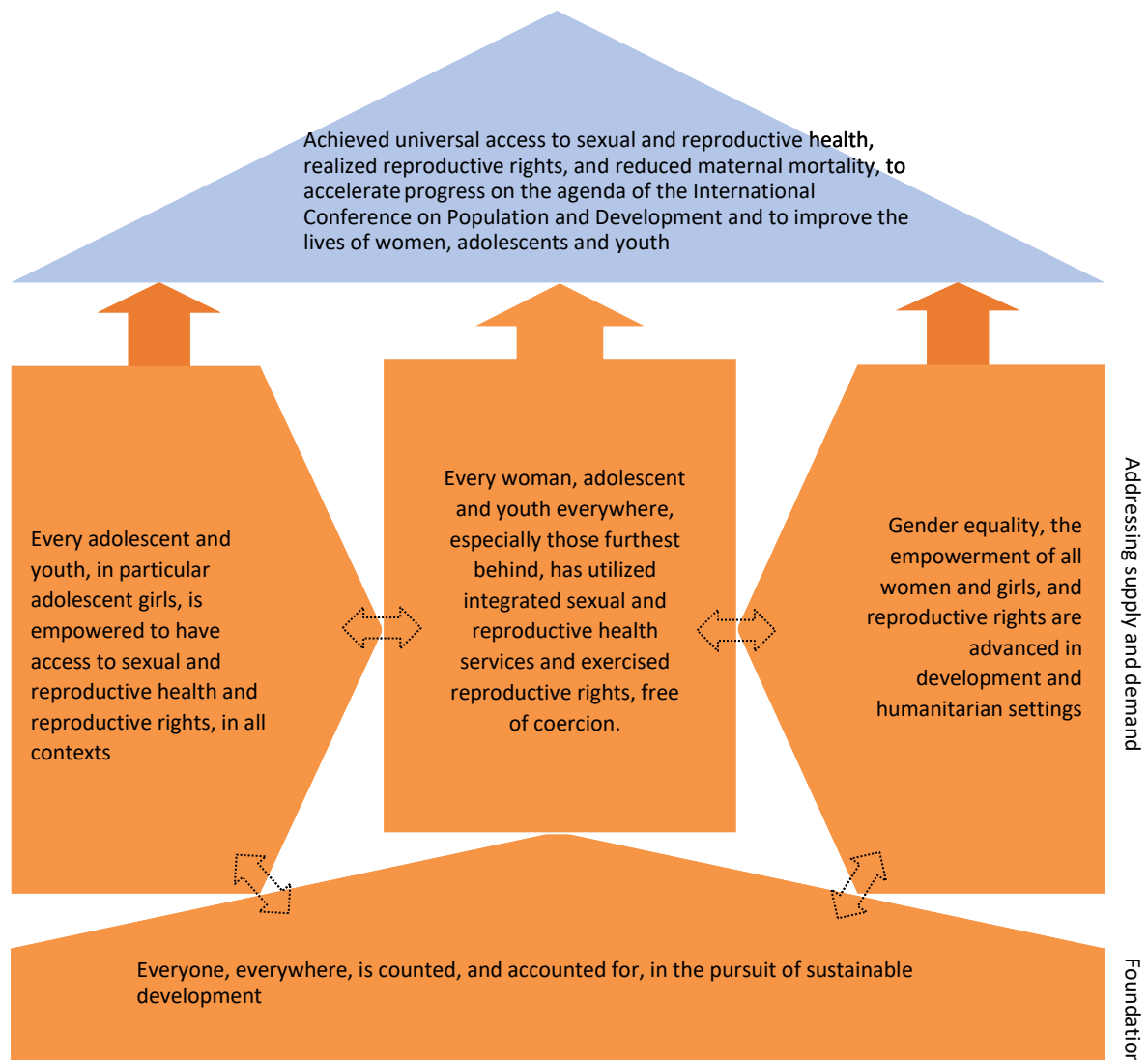
By 2019, there is effective management of explosive remnants of war and armaments and strengthened prevention of and responsiveness to manmade and natural disasters

4. EMPOWERMENT OF WOMEN

Outcome 13.

By 2019, coordinated multi-sectoral platforms prevent and timely respond to gender based violence and provide comprehensive care and support to survivors.

Annex 10 Summary of the UNFPA Strategic Plan 2018-2021 theory of change



Protecting and promoting human rights

Prioritizing “leaving no one behind” and “reaching the furthest behind first”

Ensuring gender responsiveness

Reducing risk and vulnerabilities and building resilience

Strengthening cooperation and complementarity among development and humanitarian action and sustaining peace

Improving accountability, transparency and efficiency

Principles

Annex 11 Overview of SDGs and targets relevant for UNFPA CP

	Targets
SDG 3 Ensure healthy lives and promote well-being for all at all ages	<p>3.1. By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births</p> <p>3.3. By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases</p> <p>3.7. By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes”, while the activities related to maternal mortality surveillance are related to SDG target</p>
SDG 5 Achieve gender equality and empower all women and girls	<p>5.2. Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation</p> <p>5.6. Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences</p>
SDG 10 Reduce inequality within and among countries/territory	<p>10.2 By 2030, empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status</p> <p>10.7 Facilitate orderly, safe, regular and responsible migration and mobility of people, including through the implementation of planned and well-managed migration policies</p>
SDG 17 Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development	<p>17.18 By 2020, enhance capacity-building support to developing countries, including for least developed countries and small island developing States, to increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts</p> <p>17.19 By 2030, build on existing initiatives to develop measurements of progress on sustainable development that complement gross domestic product, and support statistical capacity-building in developing countries</p>

Annex 12 Overview of CPDs and focus areas

Sexual and Reproductive Health and Rights (and Youth)		
	Outcomes	Outputs
CPD 2010-2014	<ol style="list-style-type: none"> 1. The Government, at all levels, coordinates, monitors and revises health, health education and family planning policies so that they are evidence-based and inclusive of the elderly, women and youth, by addressing gender equality, youth and the rights of youth, women and the elderly 2. Service providers in reproductive health, reproductive health education and social protection ensure access to high-quality services for socially excluded youth and women 3. The Government, at central and local levels, develops regulatory and institutional frameworks to prevent and respond to HIV and AIDS and to sexually transmitted infections 	<ol style="list-style-type: none"> 1. Health ministries coordinate and develop intersectoral family planning and reproductive health commodity security policies and strategies to improve women's health 2. Local government and social-sector institutions in selected municipalities adopt standard methodologies to plan, implement and monitor local action plans for the elderly, and to ensure their participation 3. Service providers in the health, education, social protection and judiciary sectors have improved knowledge and skills to increase the access of youth and women to high-quality social services, and to empower them to make decisions on nutrition and reproductive health 4. The Ministry of Civil Affairs and the National Advisory Board on HIV/AIDS have the technical knowledge to develop and implement participatory, evidence-based policies, strategies and standards on health and on HIV and AIDS
CPD 2015-2019(2020)	Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access	Increased national capacity at state and entities level to deliver integrated sexual and reproductive health services with focus on Roma and vulnerable populations
Youth		
	Outcomes	Outputs
CPD 2015-2019(2020)	Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health	Increased national capacity to conduct evidence-based advocacy for incorporating the human rights and needs of adolescents and youth in national laws, policies and programmes, including in humanitarian settings
Gender Equality		
	Outcomes	Outputs
CPD 2010-2014	Security sector and law enforcement sector agencies integrate gender equality issues and mainstream gender into their policies and protocols, including those on gender-based violence	<ol style="list-style-type: none"> 1. National- and entity-level government officials have increased knowledge and skills to integrate gender and women's rights, including the adoption of United Nations resolution 1325, into multisectoral, inclusive social policies 2. Officials of entity-level ministries of justice and the interior, and police at local levels, have improved knowledge and skills to establish policies and protection systems for gender-based violence and to establish multisectoral referral mechanisms
CPD 2015-2019(2020)	Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth	<ol style="list-style-type: none"> 1. Tracking and reporting mechanism to follow up on the implementation of reproductive rights recommendations and obligations established at state and entities level 2. Gender-based violence prevention, protection and response integrated into national sexual and reproductive health programmes
Population Development/Dynamics		
	Outcomes	Outputs

CPD 2010-2014	The Government, at all levels, is able to base policies on a quantitative and qualitative analysis of disaggregated data, policy assessments and reviews, with attention focused on socially excluded groups and migrant populations	<ol style="list-style-type: none"> 1. Statistical agencies have the technical knowledge and skills to conduct the 2011 census and to collect and analyse social and demographic data to develop population policies 2. Government and statistical agencies have increased knowledge and skills to establish a migration surveillance system and to integrate it into the development and implementation of strategies and policies 3. Officials of the Directorate for Economic Planning have the knowledge and skills to implement the Madrid International Plan of Action on Ageing through the European regional implementation strategy and through strategies for the elderly
CPD 2015-2019(2020)	Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics, and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality	<ol style="list-style-type: none"> 1. Strengthened institutional capacity for the formulation and implementation of rights-based policies that integrate evidence on emerging population issues (low fertility, ageing and migration) and their links to sustainable development